MARK J. CORONEL M.D., P.C.

Specializing in Gastroenterology, Hepatology and Nutrition

DATE:_____/_____/_____

NAME: _____ AGE: _____ BIRTHDATE:_____/_____/_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE: HOME: (_____) _____ WORK: (_____)_____

CELL: (_____) _____ E-MAIL: _____

SS#: _____ SEX: _____ MARITAL STATUS:_____

EMPLOYER NAME: _____ OCCUPATION:_____

EMPLOYER ADDRESS:_____

PRIMARY MD NAME: _____ PHONE: (_____) _____

EMERG. CONTACT NAME: _____ EMERG. PHONE: (_____)_____

RELATIONSHIP TO PT.:_____

PHARMACY NAME, ADDRESS & PHONE NUMBER :

_____

PRIMARY INSURANCE INFORMATION

MEDICARE # (if applicable): _____

INSURANCE COMPANY NAME:_____

I.D. #: _____ GROUP #: _____

POLICY HOLDER'S NAME:_____ RELATIONSHIP TO PT.: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH:_____/_____/_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:_____

I.D. #: _____ GROUP #: _____

POLICY HOLDER'S NAME:_____ RELATIONSHIP TO PT.: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH:_____/_____/_____

I hereby authorize the Doctor Mark J. Coronel of Mark J. Coronel M.D., P.C. to furnish any and all records pertaining to medical history, services rendered,or treatment given to me or my department for purposes of review, investigation, or evaluation of claims. I authorize payment of medical benefits to Mark J. Coronel M.D., P.C., and acknowledge that I am financially responsible for any unpaid balance and that should it become neccesary, any and all reasonable collection/attorney fees will be added to the patient's bill. I hereby authorize Mark J. Coronel M.D., P.C. to apply for benfits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company be made directly to Mark J. Coronel M.D., P.C. I certify that the information I have reported with regard to my insurance coverage is correct. I am responsible for obtaining all approiate referrals in accordance with my insurance plan. If I do not fulfill my responsibility, I will be responsible for payment in full for services rendered.I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

PATIENT OR AUTHORIZED SIGNATURE: _____ DATE:_____/_____/_____

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REASON FOR TODAY'S VISIT: (short sentence and check below) _____

_____

☐ heartburn/indigestion/reflux ☐ difficulty swallowing ☐ painful swallowing

☐ abdominal pain ☐ nausea/vomiting ☐ get full quickly at meals

☐ gas/flatuence ☐ bloating ☐ pain with bowel movement

☐ hemorrhoids ☐ laxative use ☐ abdominal distention

☐ belching ☐ diarrhea ☐ constipation

☐ black stools ☐ blood in stool ☐ hernia

☐ jaundice/yellow skin ☐ incontinence of stool ☐ irregular bowel habits

☐ vomiting blood ☐ food/milk intolerance

☐ **NONE**

PAST MEDICAL HISTORY: (Check Box)

☐ Heart Attack ☐ Angina ☐ Heart disease ☐ Cardiac Stents ☐ Rheumatic Fever ☐ Stroke ☐ Arrhythmia

☐ Acid Reflux ☐ Colitis ☐ Hepatitis ☐ Irritable bowel ☐ Crohn's Disease ☐ Ulcers (stomach)

☐ Anemia ☐ Diverticulosis ☐ Gallstones ☐ Liver disease ☐ Ulcerative colitis

☐ High blood pressure ☐ High cholesterol ☐ Thyroid disease ☐ Arthritis/gout

☐ Alcoholism ☐ Depression ☐ Substance abuse ☐ Anorexia/bulimia ☐ Mental illness

☐ Diabetes ☐ Osteoporosis ☐ Thyroid Disease

☐ Lung disease ☐ Emphysema ☐ Asthma

☐ Tuberculosis ☐ HIV ☐ Lyme Disease ☐ Epilepsy/seizures ☐ Kidney disease ☐ Blood clots (DVT/ PE)

☐ Cancer site/date diagnosed _____

☐ Other: (please provide details) _____

_____

PAST SURGICAL HISTORY: (Check Box)

☐ Gallbladder removed ☐ Appendix ☐ Hysterectomy ☐ Tonsils ☐ Cesarean Section ☐ Heart valve

☐ Hernia ☐ Abdominal Aortic Aneurysm repair ☐ Other: _____

_____

ALLERGIES: (List allergies to medications and reactions): _____

_____

MEDICATIONS: (please list all and include herbal, over the counter and birth control pills)

Name **Dose** (mg, g) **Frequency**

_____

_____

_____

_____

SOCIAL HISTORY (circle yes or no):

Yes No – Do you smoke cigarettes? If yes, how much daily? _____

If you previously smoked, when did you quit?_____

Yes No – Do you drink alcohol? If yes, how much in a week? _____

Yes No – Do you drink coffee or tea? If yes, how much daily? _____

Yes No – Have you traveled recently to tropical countries? If yes, where? _____

Yes No – Have you ever received a blood transfusion (# of units/when?) _____

– What is your Occupation? _____

– Marital Status and Children?_____

FAMILY HISTORY: please indicate if your parents, grandparents, aunts, uncles, children, siblings have:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon cancer Y N Rectal cancer Y N		Esophagus Cancer Y N		Bleeding Problems Y N	
Stomach cancer Y N		Liver Cancer Y N		Kidney problems Y N	
Pancreas Cancer Y N		Crohns Disease Y N		Heart Disease Y N	
Colon Polyps Y N		Ulcerative Colitis Y N		Liver Disease Y N	

REVIEW OF SYSTEM:

General:

- ☐ Change in general health
- ☐ Change in strength/stamina
- ☐ Fevers/sweats

Ears, Nose,Throat:

- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Sore throat/voice changes

Endocrine:

- ☐ Unusual change in weight
- ☐ Fatigue/lethargy
- ☐ Change in appetite

Skin:

- ☐ Rash
- ☐ Discoloration
- ☐ Hair Loss

Heart and Circulation:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling in legs

GenitoUrinary:

- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Change in sexual function

Lungs:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sleep Apnea or Use CPAP

Stomach/ Intestines/Digestion:

- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Bloating/gas
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Belching
- ☐ Rectal bleeding
- ☐ Abnormal bowel sounds
- ☐ Hemorrhoids

Neurologic:

- ☐ Headache
- ☐ Poor balance
- ☐ Tingling in fingers/toes

Muscles/Bones:

- ☐ Joint aches
- ☐ Muscle weakness/pain

Mood:

- ☐ Anxiety/depression
- ☐ Poor sleep
- ☐ Difficulty concentrating

Allergy:

- ☐ Hives/swelling
- ☐ Allergic reaction to medicine

Eyes:

- ☐ Change in vision

Blood:

- ☐ Excessive Bleeding
- ☐ History of blood clots
- ☐ Anemia (low blood count)

MARK J. CORONEL M.D., P.C

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our notice of Privacy Practices, which details how we may use and /or disclose your health information. An acknowledgment that the patient has received our privacy notice is required under the HIPAA regulations. To do this, we will have each patient fill out and sign this form and will be placed in the medical record. If there is revision to our privacy policy, we will promptly distribute and acknowledge this new notice of Privacy Practices.

By signing below, I hereby acknowledge receipt of the Practice's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone_____

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Cell Number_____

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Work Number_____

☐ OK to leave message with detailed information ☐ Leave message with call back number only

I AUTHORIZE MARK J. CORONEL M.D., P.C. TO RELEASE MEDICAL INFORMATION TO:

1. NAME_____RELATIONSHIP_____PHONE #_____

2. NAME_____RELATIONSHIP_____PHONE #_____

PRINT NAME_____ SIGNATURE_____ DATE_____