

# Digestive Disease Consultants

A Division of Capital Digestive Care, LLC

New Patient     Established Patient

Date \_\_\_\_\_ Acct# \_\_\_\_\_ (for office use only)

- A. Schulman, M.D.
- S. Levin, M.D.
- R. Eisdorfer, M.D.
- J. Korenman, M.D.
- L. Bassin, M.D.
- David L. Jager, M.D.
- C. Kennedy-Smith, C.R.N.P.

**Patient Information**

Patient Name: \_\_\_\_\_  
 Last Name                      First Name                      Full Middle Name

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex:    Male        Female

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Married   Single   Divorced   Widowed   Partnered

Home Address: \_\_\_\_\_  
 \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_      Your Employer: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_       Full-Time     Part-Time     Retired

Work Phone: (\_\_\_\_) \_\_\_\_\_ x \_\_\_\_\_      Email Address: \_\_\_\_\_ @ \_\_\_\_\_

<b>Emergency Contact Information</b>
Emergency Contact: _____
Phone Number: (____) _____
Relationship: _____

<b>Primary Care Physician (PCP)</b>	
Last Name _____	First Name _____
Phone Number: (____) _____	
<b>Pharmacy</b>	
_____	
Phone Number: (____) _____	

**Primary Insurance**

Carrier: \_\_\_\_\_      Member ID #: \_\_\_\_\_

Claims Address: \_\_\_\_\_      Group # \_\_\_\_\_

Relation to Policy Holder :     Self     Spouse     Parent/Guardian     Other(please specify) \_\_\_\_\_

**Policy Holder Information**

Name: \_\_\_\_\_  
 Last Name                      First Name                      Full Middle Name

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Sex:    Male        Female

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Employer: \_\_\_\_\_

Full-Time     Part-Time     Retired

**Secondary Insurance**

Carrier: \_\_\_\_\_      Member ID #: \_\_\_\_\_

Claims Address: \_\_\_\_\_      Group # \_\_\_\_\_

Relation to Policy Holder :     Self     Spouse     Parent/Guardian     Other(please specify) \_\_\_\_\_

**Policy Holder Information**

Name: \_\_\_\_\_  
 Last Name                      First Name                      Full Middle Name

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Sex:    Male        Female

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Employer: \_\_\_\_\_

Full-Time     Part-Time     Retired

**PLEASE READ AND SIGN BACK SIDE OF THIS FORM**

**ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT**

**(This is necessary to facilitate the processing of insurance claims and assure payment.)**

1. I hereby authorize and give permission for Digestive Disease Consultants (DDC) to disclose my personal health information (PHI)\* for insurance and treatment purposes only. I am allowing DDC to release all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that payments are due at the time services are rendered.
4. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.
5. This office reserves the right to charge a handling fee for any unpaid balance.

**I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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**ESTABLISHED PATIENTS ONLY:**

Your insurance company requires that we have an updated signature on file annually. By signing I am certifying that my information is correct and up-to-date:

Updated: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

Updated: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

Updated: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

Updated: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

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# DIGESTIVE DISEASE CONSULTANTS

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SHEILA G. LEVIN, M.D.  
ROBERT M. EISDORFER, M.D.  
JULIA C. KORENMAN, M.D.  
LAWRENCE A. BASSIN, M.D.  
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COLLEEN KENNEDY-SMITH, C.R.N.P

GASTROENTEROLOGY  
AND HEPATOLOGY



14955 SHADY GROVE ROAD, SUITE 150  
ROCKVILLE, MD 20850 301.340.3252 • FAX 301.340.1423 • www.ddccdocs.com

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

1. Why are you here today?
2. If pain or other symptom, please answer the following:  
Location:  
Description:  
Severity (scale 1-10 most severe):  
When first felt:  
Timing (e.g. daily, after meals):  
Anything that affects it (better or worse):  
Associated with (diarrhea, nausea, or vomiting):
3. Have you had this pain or other symptom before? If so, please answer the following:  
What tests were done?  
What was your diagnosis?  
How were you treated (e.g. medications)?
4. ALLERGIES: List names of drugs, or intravenous dye/contrast and list type of reaction, e.g. hives, rash or swelling, etc.  
  
**Latex Allergy?** Yes \_\_\_\_\_ No \_\_\_\_\_
5. List ALL of your current medications, their dosage and frequency. Include over-the-counter medications, vitamins, minerals, supplements or herbal medications.
6. Medical Conditions:      High Blood Pressure      Diabetes      Cancer      Heart Murmur  
(please circle)              Sleep Apnea              Angina              Thyroid              High Cholesterol  
Other \_\_\_\_\_
7. Any Operations, Hospitalizations, Illnesses or Injuries?
8. Any change in weight within the last year? If so, how much?

**Please continue on page two (over)...**

**SOCIAL HISTORY**

Marital Status: Occupation: Spouse's occupation:  
Do you smoke? If so, how many packs per day?  
Alcohol? If so, how many drinks per day?

Children? - How many? (Please include age & sex):

**FAMILY HISTORY**

Please include parents, grandparents, siblings, and children.

- Ages, major illnesses and cause of death, if possible.
- Family history of cancer? What kind(s)?
- Personal or family history of polyps?
- Personal or family history of celiac disease/sprue?
- Personal or family history of cirrhosis or liver disease?

**REVIEW OF SYSTEMS**

Do you have any other symptoms or complaints? (please specify) \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat** (please circle all that apply):

Change in hearing Change in taste Headaches Sore Throat Trouble Swallowing  
Change in vision Change in smell Hoarseness Swollen Glands

**Chest/Lungs** (please circle all that apply):

Shortness of breath Cough Wheeze Asthma

**Heart** (please circle all that apply):

Palpitations Shortness of breath Chest pain Swelling of the legs

**Abdomen** (please circle all that apply):

Pain Constipation Indigestion Black Stools Gas/Bloating  
Nausea/Vomiting Hemorrhoids Loss of Appetite Diarrhea Heartburn  
Rectal Bleeding Other \_\_\_\_\_

**Genitalia/Urinary** (please circle all that apply):

Frequent Urination Testicular Mass Night Urination Menopause Abnormal Menstrual Bleeding

**Musculoskeletal** (please circle all that apply):

Arthritis Swollen Muscles & Joints Back Pain Aching

**Skin** (please circle all that apply):

Rash Itching Bruising

**Neurological** (please circle all that apply):

Weakness Anxiety Depression Numbness Tingling Insomnia

**General** (please circle all that apply):

Fever Fatigue Weight Loss Weight Gain Sweats Chills

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**Federal Law ensures the privacy of your medical records, their availability to you, and specific rights regarding your medical records.**

Digestive Disease Consultants complies with these standards. As a general principle, we will always assume that you have instructed us **NOT** to release your medical records, or any portion thereof, to anyone, except under the usual, general circumstances covered below.

Please read and sign this **GENERAL AUTHORIZATION CONCERNING YOUR MEDICAL RECORDS.**

Relevant portions of my medical record may be provided to:

1. other designated doctors and their staffs (e.g., this practice; primary or referring doctors and their staffs; hospital or out-patient facilities, endoscopy unit, or surgical-day-care).
2. my medical insurance company to document specific service(s) provided and billed.
3. the Government, as required by law (e.g., subpoena)

If you wish to designate (a) person(s) (other than those above) to be given access to all or part of your medical record, please initial "ACCESS ALLOWED" below and write their name. If you wish to revoke such designation, please initial "ACCESS DENIED" below and write their name(s):

\_\_\_\_\_ **ACCESS ALLOWED**      **Name(s):** \_\_\_\_\_

\_\_\_\_\_ **ACCESS DENIED**      **Name(s):** \_\_\_\_\_

Please specify by circling the appropriate answer below, if we may leave health-related information (e.g., lab/biopsy/x-ray results, billing issues, or other doctor-patient communications) on your:

Home answering machine:    **Yes**   or   **No**

Cell Phone voicemail:        **Yes**   or   **No**

Work voicemail:                **Yes**   or   **No**

Personal email:                **Yes**   or   **No**    If yes, email address \_\_\_\_\_ @ \_\_\_\_\_

(Please print)

**(Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.)**

If you have any questions, comments, or exceptions, please speak with our Practice Administrator.

I acknowledge that I have read, understand, and agree to the above.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Account No. (Office Use Only)