4381 E. Lohman Avenue, Las Cruces, NM 88011

Lohman Endoscopy Center - Suite A
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Digestive Disease Consultants - Suite B
Phone (575) 522-7697 / Fax (575) 522-4840

Thomas V. Nattakom, MD *Ayyappa Mysore, MD* *Jean-Pierre Reinhold, MD* *Kairasp Noshirwani, MD*

Specializing in Gastroenterology / Hepatology / Colon Cancer Screenings

DATE OF APPOINTMENT:______________________ REFERRING OR PRIMARY DOCTOR:________________________________

PATIENT INFORMATION:

NAME | DATE OF BIRTH | AGE | GENDER | SOCIAL SECURITY #

( )

MAILING ADDRESS | CITY | STATE | ZIP CODE | PRIMARY PH #

EMPLOYER | PHONE # | OCCUPATION

EMERGENCY CONTACT:

NAME | RELATIONSHIP | PHONE #

INSURANCE INFORMATION:

PRIMARY COVERAGE

INSURANCE NAME | ID# | POLICY HOLDER NAME (IF DIFFERENT FROM PT) | DATE OF BIRTH

SECONDARY COVERAGE

INSURANCE NAME | ID# | POLICY HOLDER NAME (IF DIFFERENT FROM PT) | DATE OF BIRTH

I hereby authorize my insurance benefits to be paid directly to DIGESTIVE DISEASE CONSULTANTS OF LAS CRUCES and understand that I am financially responsible for non-covered services. I also authorize the physician to release information required to process this claim. I understand and agree to cover a copay at the time of service. I authorize DIGESTIVE DISEASE CONSULTANTS OF LAS CRUCES to release any medical information in connection with these services to my referring and or primary physician. **Consent to treatment:** I understand that medical treatment is of urgent nature or necessary for the patient and such medical care, treatment, and procedures will be no guarantee as to the results which may be obtained.

Patient Signature ____ **Date** ________________

Acknowledgment of Receipt of Notice of Privacy Practices

I, ______________________________, acknowledge that I received a copy of Digestive Disease Consultants' Notice of Privacy Practices. This notice explains how this office may use and disclose my protected health information, certain restrictions on the use and disclosure my health information and rights I have regarding my health information.

____ ______________________ ____________________

Signature of Patient or Personal Representative | Relationship to Patient | Date

Authorization for Release of Medical Information

I hereby authorize the physicians and staff of DDC to release my medical records whether partial or complete, prescriptions and/or medication samples, if for any reason I am unable to obtain them myself, to the following person(s) only:

(DO NOT LIST OR INCLUDE PRIMARY OR REFERRING PHYSICIANS)

	NAME	RELATIONSHIP
1		
2		
3		

Patient Information

First Name: ______________________ **Last Name:** ______________________

Patient Email: ______________________

Reason for visit: ______________________

Weight: ______________ **Height:** ______________

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish ☐ Other: __________

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Codeine ☐ Dye ☐ Erythromycin ☐ Latex ☐ Penicillins

☐ Sulfa ☐ Surgical Tape Other: __________ Other: __________ Other: __________

Current Medications

☐ None

Name	Strength

Name and Address of Pharmacy: ____________________

Immunizations

☐ None ☐ Pneumonia Date ________ ☐ Flu Date ________ ☐ Covid Date ________

Diagnostic Studies / Tests (DATE & PLACE)

☐ None

Previous Procedures (DATE & PLACE)

☐ None

Provide card for any implanted cardiac device (ex: Pacemaker, Defibrillator)

Past or Present Medical Conditions

☐ None

☐ Anemia	☐ Angina	☐ Asthma - COPD	☐ Cancer	☐ Colon Polyps
☐ Colon Cancer	☐ Diabetes Mellitus	☐ High Blood Pressure	☐ High Cholesterol	☐ Irregular Heartbeat
☐ Liver Disease	☐ Myocardial Infarction	☐ Stomach Ulcers	☐ Stroke	Other: ________

Social History

Occupation: ____________________ Number of Children: ____________________

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

☐ None

Type	Quantity	Number	Frequency

Tobacco
Smoking Status

☐ Current every day smoker ☐ Current Some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Drug Use

☐ None

Type	Quantity	Number	Frequency

Family Medical History

☐ No knowledge of family history

No family history of ☐ Autoimmune disorders ☐ Colon Cancer ☐ Gastric Cancer ☐ Polyps

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Family Hx of Colon CA	○	○	○	○	○	○	○	○	○	○
Family Hx of Colon Polyps	○	○	○	○	○	○	○	○	○	○
Family Hx of Digestive Disorders	○	○	○	○	○	○	○	○	○	○

Review of Systems

Cardiovascular

☐ None

	Yes	No
chest pain	○	○
irregular heart beat	○	○
palpitations	○	○
dyspnea with exercise	○	○

Constitutional

☐ None

	Yes	No
fever	○	○
chills	○	○
sweats	○	○
loss of appetite	○	○
chronic fatigue	○	○
change in weight	○	○

ENMT

☐ None

	Yes	No
blurring	○	○
nose bleeds	○	○
sore throats	○	○
hoarseness	○	○

Endocrine

☐ None

	Yes	No
heat intolerance	○	○
cold intolerance	○	○

Gastrointestinal

☐ None

	Yes	No
abdominal pain	○	○
heartburn	○	○
gas	○	○
constipation	○	○
diarrhea	○	○
nausea	○	○
vomiting	○	○
rectal bleeding	○	○
stomach cramps	○	○
abdominal swelling	○	○
jaundice	○	○
change in bowel habits		○
hematochezia	○	○

Genitourinary

☐ None

	Yes	No
dysuria	○	○
frequent urination	○	○
hematuria	○	○
frequent urinary infections	○	○

Hematologic / Lymphatic

☐ None

	Yes	No
easy bruising	○	○
prolonged bleeding	○	○
bleeding gums	○	○
palpable lymph nodes	○	○

Integumentary

☐ None

	Yes	No
rashes	○	○
jaundice	○	○
itching	○	○

Musculoskeletal

☐ None

	Yes	No
joint pain	○	○
back pain	○	○
arthritis	○	○

Neurological

☐ None

	Yes	No
seizures	○	○
frequent headaches	○	○
stroke	○	○

Psychiatric

☐ None

	Yes	No
depression	○	○
anxiety	○	○
suicidal ideation	○	○

Respiratory

☐ None

	Yes	No
cough	○	○
wheezing	○	○
asthma	○	○
shortness of breath	○	○

Signature **Date**