601 Omega Dr. Suite 201
Arlington, TX 76014

Fatema S. Uddin, MD, PLLC
Gastroenterology

Phone: 817-467-4488
Fax: 817-472-7385

Patient's Name: _____ **SS#:** _____
First Name Middle Initial Last Name

Date of Birth: _____ ☐ Male ☐ Female

Street Address: _____ **City/State/Zip code:** _____

Primary Phone #: ( ) _____-_____ **Secondary Phone #:** ( ) _____-_____

Work Phone #: ( ) _____-_____ **Email:** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ White/ Caucasian

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

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

PLEASE LIST YOUR PREFERRED PHARMACY

Pharmacy Name: _____ **Address or Cross Streets:** _____

Phone Number: _____

In case of emergency, contact name: _____

Phone #: ( ) _____-_____ **Relationship to Patient:** _____

Referring Physician's Name: _____ **Phone #:** ( ) _____-_____

Primary Care Physician's Name: _____ ☐ **Same Phone #:** ( ) _____-_____

Do you have an advanced directive or living will? Please CIRCLE: Yes or No

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PLEASE PROVIDE INSURANCE INFORMATION BELOW

Primary Insurance Company: _____

Primary Insured's Name: _____ **Date of Birth:** _____

Primary Insured's SS#: _____ **Relationship:** _____

Policy #: _____ **Group #:** _____

Secondary Insurance Company: _____

Secondary Insured's Name: _____ **Date of Birth:** _____

Secondary Insured's SS#: _____ **Relationship:** _____

Policy #: _____ **Group #:** _____

> I hereby authorize the payment of medical benefits to Fatema S. Uddin, MD, PLLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

> I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.

> I hereby authorize Fatema S. Uddin, MD, PLLC to release any medical information necessary to complete and process my insurance claims.

> I hereby authorize Fatema S. Uddin, MD, PLLC to treat me and use my person health information for heathcare operations

>>_____ _____

>> Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

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MEDICAL HISTORY/CONDITIONS
(Check all that apply)

- ☐ Acid Reflux Disease / GERD
- ☐ AIDS/HIV Positive **(Circle)**
- ☐ Anemia (Diagnosed by physician)
- ☐ Arthritis / Osteoarthritis **(Circle)**
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Cancer **(What Type)** _____
- ☐ Celiac Disease
- ☐ Chemical Dependency
- ☐ Crohn's Disease
- ☐ Diabetes- Type I / Type II **(Circle)**
- ☐ Diverticulitis / Diverticulosis **(Circle)**
- ☐ Emphysema
- ☐ Epilepsy/Seizures **(Circle)**
- ☐ Fatty Liver
- ☐ Heart Disease:
  Cardiologist _____
- ☐ Hemorrhoids
- ☐ Hepatitis A / B / C **(Circle)**
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Colon Polyps
- ☐ History of H. Pylori Infection
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Cirrhosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Prostate Disease
- ☐ Psychiatric Care
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke / Heart Attack **(Circle)**
- ☐ Thyroid Disease-
  Overactive / Underactive **(Circle)**
- ☐ Ulcerative Colitis
- ☐ **Other:** _____

PAST SURGICAL HISTORY

(list all surgeries / procedures you have had and the **year**)

1. _____ Yr _____
2. _____ Yr _____
3. _____ Yr _____
4. _____ Yr _____
5. _____ Yr _____
6. _____ Yr _____
7. _____ Yr _____
8. _____ Yr _____
9. _____ Yr _____
10. _____ Yr _____

Date of Last Upper Endoscopy: _____ Performing Dr. _____
Date of Last Colonoscopy: _____ Performing Dr. _____
Polyps Removed? Yes / No **(Circle)**

CURRENT MEDICATIONS WITH DOSAGE

1. _____ MG _____
2. _____ MG _____
3. _____ MG _____
4. _____ MG _____
5. _____ MG _____
6. _____ MG _____
7. _____ MG _____
8. _____ MG _____
8. _____ MG _____
9. _____ MG _____
10. _____ MG _____
11. _____ MG _____
12. _____ MG _____
13. _____ MG _____
14. _____ MG _____
16. _____ MG _____

DRUG ALLERGIES

_____ _____
_____ _____

PAST HOSPITALIZATIONS **REASON AND THE YEAR**

_____ Yr _____ _____ Yr _____
_____ Yr _____ _____ Yr _____

FAMILY HISTORY **List any known illnesses, cancers, or conditions**
(Do not list family member's names or ages)

Mother: _____ Alive / Deceased **(Circle)**
Father: _____ Alive / Deceased **(Circle)**
Siblings: _____ Alive / Deceased **(Circle)**
Maternal GM: _____ Alive / Deceased **(Circle)**
Maternal GF: _____ Alive / Deceased **(Circle)**
Paternal GM: _____ Alive / Deceased **(Circle)**
Maternal GF: _____ Alive / Deceased **(Circle)**

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Instructions: Please check YES to sypmtoms you are currently experiencing and NO to symptoms you are not feeling today or within the past week.

NEUROLOGICAL

- ☐ Yes ☐ No Fatigue (sluggish, tired)
- ☐ Yes ☐ No Restlessness at Night
- ☐ Yes ☐ No Seizures

EMOTIONAL / MENTAL

- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Mood Swings
- ☐ Yes ☐ No Lack of Concentration
- ☐ Yes ☐ No Stress

HEAD / EARS / EYES

- ☐ Yes ☐ No Headaches (any kind)
- ☐ Yes ☐ No Decreased Hearing
- ☐ Yes ☐ No Glaucoma

NASAL / SINUS

- ☐ Yes ☐ No Post Nasal Drip
- ☐ Yes ☐ No Sinus Pain
- ☐ Yes ☐ No Stuffy Nose

MOUTH / THROAT

- ☐ Yes ☐ No Sore Throat
- ☐ Yes ☐ No Swollen Throat
- ☐ Yes ☐ No Swelling of Lips / Tongue
- ☐ Yes ☐ No Gagging / Choking
- ☐ Yes ☐ No Lesions ("Canker Sores")
- ☐ Yes ☐ No Difficulty Swallowing
- ☐ Yes ☐ No Painful Swallowing
- ☐ Yes ☐ No Chronic Belching

LUNGS

- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Chest Congestion
- ☐ Yes ☐ No Non-Productive Coughing
- ☐ Yes ☐ No Productive Coughing

GENITOURINARY

- ☐ Yes ☐ No Increased Urinary Frequency
- ☐ Yes ☐ No Painful Urination
- ☐ Yes ☐ No Blood in Urine
- ☐ Yes ☐ No Lack of Bladder Control

MUSCULOSKELETAL

- ☐ Yes ☐ No Joint Pains / Aching
- ☐ Yes ☐ No Muscle Aches

GASTROINTESTINAL

- ☐ Yes ☐ No Heartburn / Indigestion
- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Bloating Sensation
- ☐ Yes ☐ No Excessive Flatulence
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Painful Elimination
- ☐ Yes ☐ No Poor Appetite
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Fecal Incontinence
- ☐ Yes ☐ No Black / Tarry Stools
- ☐ Yes ☐ No Change in Bowel Pattern
- ☐ Yes ☐ No Blood in Stool
- ☐ Yes ☐ No Rectal Pain / Pressure

SOCIAL HISTORY, PART I

☐ Yes ☐ No Do you smoke?
If Yes, How many packs per day? ____
How many years? _____
If Quit, When? _____

☐ Yes ☐ No Have you ever traveled outside the US within the past year?
If Yes, Where? _____
_____

SOCIAL HISTORY, PART II

☐ Yes ☐ No Do you drink alcohol?
If Yes, What Type? Please Circle
Liquor Beer Wine
How often? _____
How Many Glasses Per Occasion? _____

☐ Yes ☐ No Have you ever had a blood transfusion?
If Yes, When? _____

☐ Yes ☐ No Do you have history of Drug Use?

SOCIAL HISTORY, PART III

☐ Yes ☐ No Do you drink caffeine?
If Yes, What Type? Please Circle
TEA COFFEE SODA

How many cups per day? Please Circle
1 2 3 4 >5

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FINANCIAL POLICY

Patient Name: _____ **DOB:** _____
(Please Print)
Date: _____

Thank you for choosing Fatema S. Uddin, MD, PLLC for your gastrointestinal care. We are committed to the highest quality of care. As part of the provider/ patient relationship, we believe that it is important for you to understand our Financial Policy regarding payment for services. We ask that you review and sign this policy prior to any treatment.

REGARDING INSURANCE COVERAGE

We serve as a participating provider with a variety of insurance plans. All fees for co-pays, deductibles and non-covered services will be collected at the time of the visit. We accept cash, checks, credit cards, and money orders.

The balance of all visits/ treatments is your responsibility whether your insurance company pays or not. In order to bill your insurance, it is necessary for you to bring in all insurance information. If you do not provide us with the correct insurance information at the time of service and this results in non-payment by your insurance company, then you will be responsible for the payment of your visit. If your insurance coverage is with an HMO or other managed Care program, we will bill them for you only if you present an authorization for services from them. It is the patient's responsibility to obtain a proper referral for the visit. Your referral must be in our office at the time of the visit. If you do not have an authorization for each visit and/ or treatment, the responsibility for payment will be yours and must be paid at the time of service. If you wish to use your health savings account/FLEX account for your copayment/ coinsurance, then you will need to bring the appropriate payment modality to your visit. We will need to collect this at the time of the visit. There will be a $25.00 fee for completing any outside paperwork.

Returned Check Fee: There is a $30.00 returned check fee. The original amount of the check plus the returned check fee must be paid within 10 days of when the check was returned. If we do not receive the payment as stated, we will submit the returned check to the District Attorney's office for legal action.

We require a 24-hour notice for all cancellations and reschedules for appointments and procedures. If you fail to provide the proper notice, there will be a $75.00 fee for cancellations of office appointments and a $150.00 fee for procedures.

Requests for medical records require a release of medical records form signed by the patient. A base fee of $50.00 will be charged patient. A base fee of $50.00 will be charged when copies of medical records are requested by patients.

All fees that are due must be paid prior to scheduling a subsequent appointment or procedure.
I have read the Financial Policy (above). I understand and agree to this Financial Policy.

Signature of Patient/ Responsible Party

_____ Date:_____

Signature of Co-Responsible Party

_____ Date:_____

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Acknowledgement of Receipt of Privacy Notice

I acknowledged that I have received a copy of Provider's Notice of Privacy Practices.

In addition to the entities listed on the privacy policy, I give my permission to disclose my medical and personal information to disclose my medical and personal information to the following persons and entities:

1. _____
2. _____
3. _____
4. _____
5. _____

Signature of Patient/ Patient Representative

_____ Date:_____

Relationship to Patient

_____ Date:_____