4381 E. Lohman Avenue, Las Cruces, NM 88011

Lohman Endoscopy Center - Suite A
Phone (575) 522-3220 / Fax (575) 522-6212

Digestive Disease Consultants - Suite B
Phone (575) 522-7697 / Fax (575) 522-4840

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

Specializing in Gastroenterology / Hepatology / Colon Cancer Screenings

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Either you or your referring physician recently requested an appointment for a Colonoscopy with one of our providers. In order for us to determine the type of appointment to schedule for you, please answer the following questions by circling YES or NO for each one:

YES **NO** I am having symptoms such as diarrhea, constipation, abdominal or stomach pain, rectal bleeding, change in bowel habits or heartburn. If you chose yes, please indicate your symptoms):_____

YES **NO** I take prescription blood thinners such as Coumadin or Plavix.

YES **NO** I have had a heart valve replacement or major heart surgery.

YES **NO** I have COPD, sleep apnea, or other breathing difficulties. If you chose yes, please indicate which one(s):_____

YES **NO** I have previously had a Colonoscopy. If yes, please indicate the date it was done.
_____

Signature:_____ **Date:**_____

If patient has implanted defibrillator, bring manufacturer card.

We would like to thank you for choosing us as your healthcare provider!

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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

fever	○	○
chills	○	○
sweats	○	○
loss of appetite	○	○
chronic fatigue	○	○
change in weight	○	○

ENMT

☐ None

blurring	○	○
nose bleeds	○	○
sore throats	○	○
hoarseness	○	○

Endocrine

☐ None

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

dysuria	○	○
frequent urination	○	○
hematuria	○	○
frequent urinary infections	○	○

Hematologic / Lymphatic

☐ None

easy bruising	○	○
prolonged bleeding	○	○
bleeding gums	○	○
palpable lymph nodes	○	○

Integumentary

☐ None

	Yes	No
rashes	○	○
jaundice	○	○
itching	○	○

Musculoskeletal

☐ None

joint pain	○	○
back pain	○	○
arthritis	○	○

Neurological

☐ None

seizures	○	○
frequent headaches	○	○
stroke	○	○

Psychiatric

☐ None

depression	○	○
anxiety	○	○
suicidal ideation	○	○

Respiratory

☐ None

cough	○	○
wheezing	○	○
asthma	○	○
shortness of breath	○	○

Signature **Date**

You have the right to designate a personal representative This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information – This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information – This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information – This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability – This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if your believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment – We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment – Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations – We may use or disclose, as-needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law – We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health – We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases – We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight – We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect – We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

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