WESTERN MASS.
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Dear New Patient:

Greetings and welcome to our practice. Thank you for choosing us you to provide your gastroenterology care.

Please find the following enclosed documents:

1. PATIENT INFORMATION FORM
2. AN OPEN LETTER TO OUR PATIENTS
3. PATIENT'S PERSONAL HISTORY
4. Privacy Notice
5. Acknowledgement of Notice of Privacy Practices
6. WESTERN MASS G.I. ASSOCIATES Practice Brochure
7. Appointment Card

To expedite your visit, please complete the PATIENT INFORMATION FORM, PATIENT'S PERSONAL HISTORY, and Acknowledgement of Notice Privacy Practices and bring them with you to your appointment.

In addition, we require that you bring the following:

1. Current insurance card(s)
2. Photo identification
3. List of current medications, both prescription and over the counter, including dosages
4. Copy of your medical records (related to your current problem), including doctor reports, x-rays, laboratory results, and the like.

If your insurance plan requires a referral from your primary care physician for you to see a specialist, please remember that it is your responsibility to obtain it.

Lastly, if you are unable to keep your appointment, kindly give us 24 hours notice.

As a practice, we are committed to providing the highest quality of patient care. Your efforts to provide the information requested will help us in this effort. Thank you.

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AN OPEN LETTER TO OUR PATIENTS

We will all be faced with a variety of challenges and changes, however no matter how hard we try there are some things we simply just cannot change.

One of which is insurance referrals. Please, understand that we are committed to giving you the best in patient care but sometimes your insurance company ties our hands.

There is some confusion regarding who is responsible for getting your referral. Even though your primary care physician makes the appointment for you to see us, you are responsible for making sure you have our referral either called in prior to or in-hand when you arrive for your appointment.

It is very important that you understand your insurance plan. If you have any questions call the telephone numbers listed on your card.

If you arrive at our office without the proper referral you will be required to sign a waiver or reschedule your appointment depending upon the type of insurance you have.

Most importantly, it is not the responsibility of our staff to get your insurance referral, but we will be happy to assist you if it can be done in a timely manner.

Sincerely,

WESTERN MASS GI ASSOCIATES

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Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. "This is required by Law".

WMGI is committed to protect our patients right to privacy. We will not disclose any information to an unauthorized source without your written release or records. Obviously, to ensure the continuity of your care there are organizations or entities that help provide these services. For example, our billing service, your insurance company, your PCP, the transcription company. These kinds or entities are an integral part of the healthcare system and are contracted to protect your privacy, as well. Information will be provided to these entities, without your written consent as necessary.

Protected Healthcare information may be released without your permission under certain situations. For example: Public Health issues, emergencies, requirements under law enforcement or for national defense and security. If disclosure is necessary WMGI will attempt to notify you.

You, as a patient have a right to see and copy your medical records and request amendments or corrections. There is a statement on the intake sheet requesting your permission to leave messages on your answering machine or with a family member. You have the right to prohibit this.

If you have questions or concerns you may contact the Practice manager. If you have a complaint you may file with the covered entity or secretary to the Department of Health and Human Services with no retaliation.

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Acknowledgement of Notice of Privacy Practices

Western Mass Gastroenterology Associates Notice of Privacy Practices provides you with information about how we may use and disclose your protected health information.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of patient or patient's authorized representative Date

_____

Relationship to patient

_____ Notice of Privacy Practices Given - patient unable to sign

_____ Notice of Privacy Practices Given - patient declined to sign

PATIENT'S PERSONAL HISTORY

Date _____

PLEASE FILL OUT AND BRING MEDICAL RECORDS WITH YOU TO YOUR APPOINTMENT

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place

Describe briefly your present medical symptoms:

FAMILY HISTORY	IF LIVING			IF DECEASED	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters* (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* (Circle Sex)					
	M F				
	M F				
	M F				
	M F				
	M F				

*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any blood relative who has or had: (Check and give relationship)

- ❒ Stroke _____
- ❒ Cancer _____
- ❒ Migraine _____
- ❒ Tuberculosis _____
- ❒ Diabetes _____
- ❒ Bleeding tendency _____
- ❒ Epilepsy _____
- ❒ Suicide _____
- ❒ Asthma _____
- ❒ Hay Fever _____
- ❒ Arthritis _____
- ❒ Heart Attack _____
- ❒ Stomach Ulcers _____
- ❒ High Blood Press. _____
- ❒ Goiter _____
- ❒ Leukemia _____
- ❒ Congenital heart _____
- ❒ Colon Polyps _____
- ❒ Rheumatic Heart
- ❒ Kidney Disease
- ❒ Colitis

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? ❒ Pipe ❒ Cigar How many? _____ How many years? _____

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? ❒ 1 oz. per day ❒ 2 oz. per day ❒ 4 oz. per day over ❒ 6 oz. per day

BEER: ❒ 1 bottle per day ❒ 2 bottles per day ❒ over 4 bottles per day

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

Yes No Have you had transfusions?

Yes No Have you been a blood donor?

Yes No Have you had any recent weight change? How much? _____

Yes No Do you regularly drink milk? How much? _____

Yes No Do you use artificial sweetener? How much? _____ Type? _____

MEDICATIONS:

Please list all medicines and pills you are taking (including vitamins, supplements, etc.)

Medication	Dose	Medication	Dose

Write in the names and year of any operations which you have had: (with date, place, doctor)

_____

_____

_____

Name any drugs to which you are allergic:

_____

Write in the names of any diseases you have had which require hospitalization: (with date, place, doctor)

_____

_____

_____

_____

_____

Serious Illnesses which you have had not requiring hospitalization: (doctor's name)

_____

_____

_____

_____

Serious injuries or accidents:

_____

_____

_____

_____

_____

To be answered by WOMEN only: (Circle)

Yes No Are you still having regular monthly menstrual periods? _____
Yes No Have you ever had bleeding between your periods? When? _____
Yes No Do you have very heavy bleeding with your periods? When? _____
Yes No Do you feel bloated and irritable before your period? _____
Yes No Are you now on or have you ever taken the birth control pill? When? _____
Yes No Have you ever had a miscarriage? When? _____
Yes No Have you ever had a discharge from the nipple of your breast? When? _____
Yes No Do you regularly have the cancer test of the cervix? Date of last test? _____

How many children born alive _____
How many stillbirths _____
How many premature births _____
Date of last menstrual period _____

How many miscarriages _____
How many cesarean operations _____
Any complication of pregnancy _____

To be answered by men and women: (Circle)

Yes No Do you frequently have severe headaches? (If yes, answer the following)
Yes No Do they cause vision trouble?
Yes No Do they occur on one side of your head?
Yes No Do they awaken you at night from sleep?
Yes No Do they feel like a tight hat band?
Yes No Do they hurt most in the back of the head and neck?
Yes No Does aspirin relieve them?

Yes No Have you ever fainted?
Yes No Spells of dizziness?
Yes No Spells of weakness of an arm or leg?
Yes No Ringing in ears?
Yes No Nosebleeds

Yes No Have you ever had a convulsion?
Yes No Double Vision?
Yes No Low Vision?
Yes No Pains in ears

Yes No Do you frequently have bleeding gums?
Yes No Do you frequently have trouble swallowing?
Yes No Do you frequently have nausea and vomiting?

Yes No Do you frequently have a sore tongue?
Yes No Do you frequently have hoarseness?

Have you ever had shortness of breath: (Circle)

Yes No Doing your usual work?
Yes No Climbing a flight of stairs?
Yes No Which awakens you at night?
Yes No Do you have a chronic cough?

Yes No Which causes you to cough?
Yes No Accompanied by wheezing?
Yes No Have you ever coughed blood?
Yes No Do you cough up much sputum?

Last chest x-ray? _____

Have you ever had chest pain or tightness in the chest which begins when: (Circle)

Yes No When exerting yourself?
Yes No When walking against a wind?
Yes No When walking up a hill?
Yes No After a heavy meal?
Yes No When upset or excited?
Yes No Palpitations
Yes No Do you sleep on more than one pillow?

Yes No Radiates down the arm?
Yes No Disappears if you rest?
Yes No Occurs only at rest?
Yes No When walking fast?
Yes No When walking in cold weather?
Yes No Heart murmurs?
If you have chest pain or tightness please explain

_____

Have you recently had pain in the stomach which: (Circle)

Yes	No	Occurs 1-2 hours after a meal?
Yes	No	Is brought on by eating fried foods, gassy foods?
Yes	No	Awakens you at night?
Yes	No	Is relieved by antacid medications?
Yes	No	Is relieved with milk or eating?
Yes	No	Occurs while eating or immediately after?
Yes	No	Is relieved by a bowel movement?
Yes	No	Loss of appetite?

If you have had a change in bowel habit recently answer the following: (Circle)

			When or since when?
Yes	No	Crampy pain in the abdomen?	
Yes	No	Alternating diarrhea and constipation?	
Yes	No	Pain during or after bowel movement?	
Yes	No	Mucous in the stool?	
Yes	No	Blood in the stool?	
Yes	No	Ribbon-like stools?	
Yes	No	Black stools?	
Yes	No	Require use of strong laxatives or enemas?	

Have you had: (Circle)

Yes	No	Burning when urinating?	
Yes	No	Loss of control of bladder?	
Yes	No	Blood in the urine?	
Yes	No	Dark colored urine?	
Yes	No	Trouble starting to urinate?	
Yes	No	Trouble holding the urine?	
Yes	No	Getting up frequently at night?	
Yes	No	Passed a kidney stone?	

Have you recently had: (Circle)

Yes	No	Pains in calves of legs when walking?	
Yes	No	Cramps in legs at night?	
Yes	No	Pain in the big toe?	
Yes	No	Varicose veins?	
Yes	No	Phlebitis or inflamed leg veins?	
Yes	No	Swelling in the ankles?	

Have you had: (Circle)

Yes	No	Lumps in the breasts	Yes	No	Depression
Yes	No	Discharge from breast	Yes	No	Nightmares
Yes	No	Thyroid problem or goiter	Yes	No	Hallucinations
Yes	No	Diabetes	Yes	No	Joint pain or swelling
Yes	No	Anemia	Yes	No	Muscle weakness or tenderness
Yes	No	Sickle Cell	Yes	No	Recent fever
Yes	No	Parasites	Yes	No	Loss of appetite
Yes	No	Memory Loss			

To be answered by MEN only: Have you ever had: (Circle)

Yes	No	Loss of sexual activity? For how long? _____
Yes	No	Treatment for genitals (private parts)?
Yes	No	Discharge from penis?
Yes	No	Hernia (rupture)?
Yes	No	Prostate trouble?