**Killeen Digestive Disease Consultants, PA**
**Xiaotuan Zhao, MD**

**PATIENT INFORMATION**

Date :_____ Referring Physician:_____

Name:_____ Sex : (circle one) M F

Age_____ Date of Birth_____ SSN#_____ Marital Status S M D W

Address_____
Street City State Zip

Telephone Number_____ Cell:_____

Email Address:_____
(By providing your email you will gain access to your medical record VIA your email)

Pharmacy of Choice:_____

Employer:_____ Occupation:_____

Employer Address:_____Telephone:_____

**INSURANCE INFORMATION**

Primary Insurance:_____ Telephone Number:_____

Policy Holders Name:_____ _____Policy Holders Date of Birth:_____

Policy Holders SSN#:_____ID Number:_____

Secondary Insurance:_____ Telephone Number:_____

Policy Holder Name:_____ Policy Date of Birth:_____

Policy Holder SSN#:_____ID Number:_____

**EMERGENCY CONTACT**

Name:_____ Telephone Number:_____

**** All co-pays are due at the time of service****

Authorized signature is on file. By signing I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and Payment of medical benefits to the physician for services rendered

Signature_____ Date :_____

*****Everything must be filled out, if not pertained to you please fill with N/A*****

**What is your reason for your visit today**:
**1.)**_____
**2.)**_____
**3.)**_____

**Drug Allergies** (include latex allergy):_____
_____

**Current Medication List**: (please list dosage, if none please indicate none)
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Please check if you have had these in the past**

☐ Pelvic Surgery(OB/GYN) ☐ Heart or Stent Placement ☐ Hysterectomy
☐ Abdomen Surgery ☐ Stomach Surgery for Weight loss ☐ Gallbladder Surgery
❑ Colonoscopy

**Immunizations history:**
Hepatitis B: ___Yes ___ No When? _____ Hepatitis A:____ Yes ____ No When?_____
Pneumacoccal ___Yes ___ No When? _____ Flu Shot: ___Yes ____No When:____

**Family History**:
**Has any of your family** ( grandparents, parents, and siblings) ever had any of the following diseases?
**(Please check If yes)**

| **Illness** | | **Which Family member?** |
|---|---|---|
| Cancer(describe what type) | ☐ | _____ |
| Hypertension (high blood pressure): | ☐ | _____ |
| Heart Disease | ☐ | _____ |
| Diabetes | ☐ | _____ |
| Colon Cancer | ( | _____ |
| Colon Polyps | ( | _____ |
| Stomach Ulcer | ( | _____ |
| Stroke | ( | _____ |
| Other hereditary disease: | ( | _____ |

Medical History(Please check if you have the following)

| | | |
|---|---|---|
| ___ Anemia | ____ COPD | ____ Blood in Stool |
| ___ Arthritis | ____ Esophageal Stricture | ____ Heart Disease |
| ___ Chronic Abdominal Pain | ____ Chronic Constipation | ____ Ulcer |
| ___ Hyperliperdemia | ____ Hypertension | ____ Chronic Pain |
| ___ Chest Pain | ____ Chronic Liver Disease | ____ Anxiety |
| ___ Depression | ____ Food Allergies | ____ Diabetic |
| ___ Colon polyps | ____ Epilepsy | ____ Other_____ |

Social History:
Smoker? _____ Previous smoke?_____ How long have you been a non-smoker? _____

Do you drink Alcohol? _____ If yes, how often do you drink? Regular/ Occasional

Previous Drinker? _____ how long since your last drink?_____

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that I have read and/or received a copy of Dr. Xiaotuan Zhao's Notice of Privacy Practices with the effective date of August 1, 2013.

_____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

*** Original to be maintained in the Patient's Permanent medical records.***

KILLEEN DIGESTIVE DISEASE CONSULTANTS, PA
XIAOTUAN ZHAO, MD
2301 S. CLEAR CREEK RD STE 102
PHONE: 254-519-8490
FAX: 254-519-8495

***Please carefully review the following and initial beside each agreement. Sign and date the bottom of this page. This will be kept in your medical file to ensure that both parties are covered if any of these events were to arise.****

## Agreement Regarding Payment and Collection on Accounts

_____ I agree that I will be responsible for all amounts not paid/covered by my insurance for medical services rendered by Killeen Digestive Disease Consultants. I further agree that in the event that my account is referred to a collection agency for collection of any delinquent amount owed, I will be responsible for payment of all collection fees charged by the collection agency in addition to all amount owed Killeen Digestive Disease Consultants. I acknowledge that this amount is 35% of the total amount of the balance due. I further agree that in the event that a suit is instituted to collect a delinquent account, I will be responsible for all cost of the suit, including but not limited to court cost and attorney fees.

## Agreement Regarding Release of Medical Records

_____I understand that there is a charge for release of medical records to yourself or a family member. This charge $25.00 for the first twenty pages and $0.15 for each additional page, with a minimum charge of $5.00. I understand that I will have to pay this charge if I request those medical records to be released. I understand that the only exception to this is if there is an ongoing medical illness or emergency situation.

## Agreement regarding No Shows

_____ I understand I must notify the office within **48 business hours** of my scheduled **appointment** if I wish to cancel or I will be responsible for a $25.00 fee.
_____ I understand I must notify the office within **72 business hours** of my scheduled **procedure** if I wish to cancel or I will be responsible for a $50.00 fee.
_____ I understand if I 'No-Show' for two consecutive appointments and/or procedures, I may be discharged from this practice.
_____ I understand that this is a personal expense and is NOT covered by my insurance and will not apply towards any insurance benefits.

_____ _____

Signature of Patient Date

_____

Print First and Last Name Relationship to Patient

***Please carefully review the following and initial beside each agreement. Sign and date the bottom of this page. This will be kept in your medical file to ensure that both parties are covered if any of these events were to arise.****

Due to a rise in insurance denials and insurance refund requests we must remind you as the patient that it is your responsibility to provide us with your correct and up to date information in regards to insurance coverage(s) , contact telephone numbers, and mailing addresses. Please be sure to notify office personnel of any changes to your information. In the event of any insurance discrepancies, our office will contact you via phone and/or mail to correct this matter. This allows us to get your medical bills covered by your insurance(s) and avoid unnecessary bills to fall on your responsibility and/or to notify you of patient balances to avoid further collection efforts.

_____ I have provided ALL insurance policies I am actively covered under.

_____ I understand that if the insurance information I provided is false, incomplete or inaccurate I will be responsible for any charges that occur as a result of this.

**By signing below, I acknowledge that I have carefully reviewed the above information.**

_____ _____

Patient Signature Date