Thank you for choosing **GastroIntestinal Specialists (GIS)** and **Shreveport Endoscopy Center (SEC)** for your healthcare needs. We appreciate the trust you've placed in us and are committed to providing high-quality, compassionate care.

GastroIntestinal Specialists (GIS) is a professional medical practice specializing in the diagnosis and treatment of diseases affecting the esophagus, stomach, small and large intestines, liver, and pancreas.

Our physicians are board-certified gastroenterologists dedicated to delivering expert care.

Shreveport Endoscopy Center (SEC) is a state-licensed, Medicare-approved ambulatory surgery center, fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). The facility is owned and operated by the physicians of GIS and is designed for diagnostic procedures such as EGD (gastroscopy), esophageal dilation sigmoidoscopy, and colonoscopy.

At GIS, we take a collaborative approach to care. You may be seen by one of our skilled **Nurse Practitioners (NPs)** or **Physician Assistants (PAs)** during your visit. These professionals work closely with our physicians and are trained extensively in gastrointestinal conditions and treatment protocols.

Even if you do not meet directly with your physician during your appointment, rest assured that all assessments and care decisions involve physician oversight.

GIS is built on trust, quality care, and a commitment to excellence, and that commitment never wavers.

If you are scheduled for a procedure at SEC, you will receive **separate statements** for services:

- **GIS**: Professional fee (physician services)
- **SEC**: Facility fee (medications, equipment, supplies)
- **Pathology**: If biopsies are performed
- **Anesthesia**: Billed separately by **Shreveport Sedation Associates, LLC**

We will bill your insurance or Medicare for all services rendered. GIS accepts Medicare assignment and participates in most insurance networks. Please be prepared to pay your **co-pay or estimated patient responsibility** at the time of service.

As a patient at SEC, you have specific rights and responsibilities. Because the procedures performed at SEC are elective and of minimal risk, we **do not honor advance directives (such as Do Not Resuscitate orders)** within our facility.

In the event of a life-threatening emergency, we will transfer you to an acute care hospital for further treatment. If you have questions or concerns about this policy, please speak with your physician or a member of our administrative team.

We are always striving to improve and deliver the highest standard of care. If you have concerns about your experience, we encourage you to speak with a supervisor or request a feedback form from a staff member.

All comments and complaints will be reviewed, investigated, and addressed promptly. Your input is vital to our continuous quality improvement efforts.

We are honored to be part of your healthcare journey. On behalf of our physicians and staff, thank you for choosing GIS and SEC. We look forward to assisting you with your medical care.

PLEASE PRINT CLEARLY

GASTROINTESTINAL SPECIALISTS A.M.C.

Patient Name	SSN	Date of Birth	Age	Gender ❑ Female ❑ Male
Mailing/Street Address		City, State, Zip Code		

Race ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Greek ❑ Hispanic ❑ Indian ❑ Multi-Racial ❑ Native Hawaiian or other Pacific Islander ❑ White	Ethnicity ❑ Hispanic ❑ Non-Hispanic

Marital Status ❑ Divorced ❑Married ❑ Single ❑Separated ❑Widowed	Primary Care Physician	Referring Physician

Home Phone Number ( )	Day Phone Number ( )	Cell Phone Number ( )	Email Address

Patient's Employer Name	Employer Address	City, State, Zip Code

Spouse or Parent's Name	Home Phone Number ( )	Street Address	City, State, Zip Code
Spouse or Parent's Employer	Business Phone Number ( )	Emergency Contact	Phone Number ( )

IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT AND/OR MEDICAL RELEASE.

I hereby authorize GastroIntestinal Specialists, A.M.C. to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, Louisiana Research Center, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign GastroIntestinal Specialists, A.M.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ **Signature** _____

Name of Primary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number

Name of Secondary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number

AUTHORIZATION

All the personnel at GastroIntestinal Specialists, A.M.C., Shreveport Endoscopy Center, A.M.C., and Louisiana Research Center, L.L.C., take your medical confidentiality very seriously. We will not and cannot release information without your written authorization. You have two options.

Option 1 Designate up to two people that we are allowed to speak with. This authorization form, when completed and signed by you, allows our staff members to speak only with an individual or individuals you designate in the event that you are not available to receive our phone calls, or you have an adult family member that helps coordinate your medical care. You should **not** designate yourself or a physician.

If you feel, for example, comfortable allowing us to talk with another person regarding your medical care, you would want to check that box. Please check all the boxes that apply to your needs. If there is another person you wish to authorize, please complete the next section as you did the first.

I authorize employees of GastroIntestinal Specialists, A.M.C., Shreveport Endoscopy Center, A.M.C., and/or Louisiana Research Center, L.L.C., to speak with:

Name (above)	Name (above)
Phone Number (above) ☐ Appointments ☐ Account/Bill ☐ Medical Care	Phone Number (above) ☐ Appointments ☐ Account/Bill ☐ Medical Care

Option 2 If you do not want anyone other than you or your physician to receive your information you will check the box below and sign this form.

☐ I do not authorize anyone to receive information regarding my medical care.

_______________________________________ _______________

Patient's Signature Date

____

Patient's Printed Name

♦♦

REVOCATION SECTION

I hereby revoke the above authorization.

_______________________________________ _______________

Patient's Signature Date

____

Patient's Printed Name

♦♦

GASTROINTESTINAL SPECIALISTS A.M.C.

Date: _____

Name: _____ Age: _____ Gender: _____ Race: _____

Have you ever been seen by a physician in our practice? Yes No If Yes, when_____

Which physician are you scheduled to see today? _____

Which physician referred you to our office for consultation? _____

Who is your primary care physician? _____

PRESENTING COMPLAINT Briefly describe the reason for your visit.

REVIEW OF SYSTEMS Please check any symptoms you are **currently** experiencing.

DIGESTIVE TRACT
- ☐ Nausea/vomiting
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Heartburn
- ☐ Indigestion/belching
- ☐ Abdominal pain
- ☐ Bloating/gas
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Fecal incontinence
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Rectal pain/itching

GENERAL
- ☐ Change in appetite
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Weight loss _____lbs
- ☐ Weight gain _____lbs

BLOOD
- ☐ Anemia
- ☐ Blood transfusion
  Date:
- ☐ Easy bleeding/bruising
- ☐ Enlarged lymph nodes

HEART/LUNGS
- ☐ Cough
- ☐ Coughing blood
- ☐ Sputum production
- ☐ Wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Heart murmur
- ☐ Palpitations

SKIN
- ☐ Itching
- ☐ Jaundice
- ☐ Lesions
- ☐ Rash

HEALTHCARE MAINTENANCE

If you are **45** years of age or older, have you had the following?			
Colonoscopy	☐ Yes	☐ No	Date: _____
Flexible Sigmoidoscopy	☐ Yes	☐ No	Date: _____
Cologuard	☐ Yes	☐ No	Date: _____
Hemoccult stool test	☐ Yes	☐ No	Date: _____
Have you ever had an upper GI series or gastroscopy?	☐ Yes	☐ No	Date: _____
Have you had the following vaccinations:			
Influenza (Flu)	☐ Yes	☐ No	Date: _____
Pneumococcal	☐ Yes	☐ No	Date: _____
Hepatitis A	☐ Yes	☐ No	Date: _____
Hepatitis B	☐ Yes	☐ No	Date: _____

GASTROINTESTINAL SPECIALISTS A.M.C.

Name: _____ Date: _____

PAST MEDICAL HISTORY Please check the following medical conditions which apply to **you**.

☐Colon polyps
☐GERD
☐Barrett's esophagus
☐Blood thinner
Type:_____
☐Heart problems
☐AFib
☐CHF
☐Stents
☐Stroke
☐COPD
☐High blood pressure
☐Sleep apnea
☐Asthma
☐Seizures
☐Cancer Type:_____
☐Thyroid problems
☐Diabetes
☐High cholesterol
☐Kidney disease
☐Hepatitis Type:_____
☐Other _____

PAST SURGICAL HISTORY Please check the following surgeries that **you** have had in the past.

	Date		Date
☐Cholecystectomy (Gallbladder removal)	_____	☐Cancer	_____
☐Colon Surgery	_____	☐Bariatric (weight loss surgery)	_____
☐Appendectomy	_____	☐Type: ☐Lap band	_____
☐Cancer	_____	☐Gastric sleeve	_____
☐Diverticular disease	_____	☐RYGB	_____
☐IBD (Crohn's, Ulcerative Colitis)	_____	☐Other _____	_____
☐Bleeding	_____	☐Other _____	_____
☐Obstruction	_____	☐Pancreatic Surgery	_____
☐Perforation	_____	☐Liver Surgery	_____
☐Hemorrhoidectomy	_____	☐Other GI Surgery _____	_____
☐Other _____	_____	_____	_____
☐Stomach Surgery	_____	☐Hysterectomy	_____
☐Lap Nissen	_____	☐C-Section	_____
☐Ulcer disease	_____		

GASTROINTESTINAL SPECIALISTS A.M.C.

Name: _____ Date: _____

FAMILY HISTORY ☐ Patient is adopted. Family history unknown.

Father's Age _____ If deceased, age at death and cause _____
Mother's Age _____ If deceased, age at death and cause _____

Total number of brothers and sisters you have had _____

Do you have any **immediate family members (parents, siblings, or children)** that have ever had the following:

☐	Colon Polyps	Relative:		Age at Diagnosis:	
☐	Colon Cancer	Relative:		Age at Diagnosis:	
☐	Liver Disease	Relative:		Age at Diagnosis:	
☐	Diabetes	Relative:		Age at Diagnosis:	
☐	Heart Disease	Relative:		Type of Heart Disease:	
☐	Other Cancers	Relative:		Type of Cancer:	
☐		Relative:		Type of Cancer:	
☐	Other Illnesses	Relative:		Type of Illness:	
		Relative:		Type of Illness:	

SOCIAL HISTORY

What city do you live in? _____

What is your occupation? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Number of children: _____

Do you smoke or chew tobacco? ☐Yes ☐No ☐Former ☐Social

How many years? _____

Packs per day? _____

Do you vape? ☐Yes ☐No ☒Former

Do you drink alcohol? ☐Yes ☐No ☐Former ☐Social

Number of drinks? _____

Have you ever used illicit or intravenous drugs? _____

Do you use medical or recreational marijuana? _____

GASTROINTESTINAL SPECIALISTS A.M.C.

Name: _____ Date: _____

MEDICATIONS List all prescription, over the counter and herbal medications you are taking including the dosage or number of pills per day.

☐ I currently take no medications.

Do you take a GLP-1 medication?	☐Yes	☐No
Do you take blood thinners?	☐Yes	☐No
Do you take NSAIDS?	☐Yes	☐No

Medication	Dose	Frequency

DRUG ALLERGIES List all medications to which you are allergic and the kind of reaction you experienced.

☐ I do not have any drug allergies.

Allergy	Reaction

Date _____ Patient or Responsible Party Signature _____ Provider Signature _____