NORTH TEXAS GASTROENTEROLOGY, P.A.

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Diplomate of the American Board of Gastroenterology

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COLONOSCOPY PATIENT REGISTRATION & HEALTH HISTORY PACKET

⚠ STOP — IMPORTANT NOTICE FOR PATIENTS

This form is intended for **HEALTHY PATIENTS ONLY** who are not experiencing active GI symptoms. If you are experiencing any GI symptoms listed below, or see any listed specialists, please **STOP** and call our office at **(940) 898-7488** to schedule a consultation appointment.

- **GI Symptoms:** Abdominal Pain, Heartburn/Acid Reflux, Diarrhea, Constipation, Blood in Stool, Black Stool, Nausea/Vomiting, Difficulty Swallowing, Unexplained Weight Loss, Ulcers, Hiatal Hernia, Bowel Habit Changes.
- **Specialists:** Cardiologist, Pulmonologist, Neurologist, Nephrologist.

1. PATIENT DEMOGRAPHIC INFORMATION

Patient Legal Name: _____ **DOB (MM/DD/YYYY):** _____ **Age:** _____ **Sex:** [ ] M [ ] F

Ethnicity: _____ **Race:** _____ **Preferred Language:** _____

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

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____

Emergency Contact Name: _____ **Relationship:** _____ **Emergency Phone:** _____

Referring Physician (First & Last Name): _____ **Primary Care Physician (PCP):** _____

2. INSURANCE INFORMATION

☐ **Check here if you DO NOT have health insurance and will take full financial responsibility for all medical expenses.**

Primary Insurance Co: _____ **Policy / Member ID:** _____ **Group Number:** _____

Insurance Address: _____ **Insurance Phone:** _____ **Subscriber Name:** _____

Secondary Insurance Co: _____ **Policy / Member ID:** _____ **Group Number:** _____

Insurance Address: _____ **Insurance Phone:** _____ **Responsible Party / Rel:** _____

3. GENERAL HEALTH & FAMILY HISTORY

Height: _____

Weight: _____ lbs.

Current Smoker? [ ] YES [ ] NO **Quit Date:** _____

Alcohol Use? [ ] YES [ ] NO If Yes, Yrs: _____ Drinks/day: _____

Medication Allergies? [ ] YES [ ] NO

List Medication Allergies & Reactions:

_____

Have you ever been diagnosed with Colorectal Cancer?	[ ] YES [ ] NO If YES, Date: _____ Post-dx colonoscopy? [ ] Y [ ] N
Family history (1st-degree relative) of Colon Cancer?	[ ] YES [ ] NO Check: [ ] Mother [ ] Father [ ] Sibling [ ] Child (Age: ___)
Family history of Colon Polyps removed?	[ ] YES [ ] NO | Details: _____

4. PREVIOUS COLONOSCOPIES & ABDOMINAL HISTORY

Have you had a full colonoscopy with sedation? [ ] YES [ ] NO
• Total colonoscopies: _____ Date of last: _____
• Complications? [ ] YES [ ] NO
(Pain, Fever, Nausea, Bloating, Bleeding, Perforation)

Polyps removed during prior colonoscopy? [ ] YES [ ] NO
• How many times?: _____ # Polyps at last exam: _____
• Date & Provider of last colonoscopy:
_____

Diagnosed or treated for cancer of any abdominal organ? [ ] YES [ ] NO | *Organ involved:* _____
(Prostate, Ovary, Uterus, Liver, Gallbladder, Pancreas, Small Bowel, Stomach, Lymphoma)

Abdominal Surgeries History (Provide Month/Year):

☐ Gallbladder Removal (Cholecystectomy): _____

☐ Appendix Removal (Appendectomy): _____

☐ Uterus Removal (Hysterectomy): _____

☐ Hernia Repair: _____

☐ C-Section (# of surgeries ____): _____

☐ Other Abdominal Surgery: _____

5. CURRENT MEDICATIONS & MEDICAL CONDITIONS

List ALL medications taken in the last month (prescriptions, over-the-counter, supplements):

(1) _____ (2) _____ (3) _____ (4) _____
(5) _____ (6) _____ (7) _____ (8) _____

CRITICAL MEDICATION NOTICE: If you have taken any blood thinners, diabetes, or GLP-1/weight loss medications (Aspirin, Ibuprofen, Coumadin/Warfarin, Plavix, Lovenox, Pradaxa, Ozempic, Wegovy, Mounjaro, Saxenda, Semaglutide) within the last 2 weeks, **STOP filling this form and call our office immediately**.

Medical Conditions Checklist (Check YES or NO for each):

Hypertension / High Blood Pressure	[ ] YES [ ] NO	Seizures or Loss of Consciousness	[ ] YES [ ] NO
Heart Attack / Chest Pain / Angina	[ ] YES [ ] NO	Crohn's Disease or Ulcerative Colitis	[ ] YES [ ] NO
Irregular Heartbeat / Arrhythmia	[ ] YES [ ] NO	Bleeding Disorders or Anemia	[ ] YES [ ] NO
Stroke / TIA (Mini-stroke)	[ ] YES [ ] NO	Kidney Disease or Impairment	[ ] YES [ ] NO
Diabetes ([ ] Insulin Dependent)	[ ] YES [ ] NO	Hepatitis or HIV	[ ] YES [ ] NO
Asthma / COPD / Emphysema	[ ] YES [ ] NO	Thyroid Disease	[ ] YES [ ] NO
Sleep Apnea (Use CPAP? [ ] Y [ ] N)	[ ] YES [ ] NO	Chemotherapy / Radiation History	[ ] YES [ ] NO

6. ADDITIONAL MEDICAL & CARDIAC QUESTIONS

Heart or Lung Surgery history?	[ ] YES [ ] NO	Adverse reaction to anesthesia?	[ ] YES [ ] NO
Pacemaker or Defibrillator implanted?	[ ] YES [ ] NO	Cold, cough, or breathing difficulty?	[ ] YES [ ] NO
Artificial Heart Valve / Endocarditis history?	[ ] YES [ ] NO	Prosthetic joints or implanted devices?	[ ] YES [ ] NO
Loose/capped teeth, crowns, or dentures?	[ ] YES [ ] NO	Back, neck, or jaw problems?	[ ] YES [ ] NO
Pre-procedure antibiotics required for dental?	[ ] YES [ ] NO	Chance of pregnancy? (LMP: _____)	[ ] YES [ ] NO

7. PREFERRED PHARMACY

Pharmacy Name: _____ **Phone:** _____ **City/State:** _____

Pharmacy Address / Cross Streets: _____

8. PATIENT CONSENT, AUTHORIZATION & OFFICE POLICIES

1. Consent to Examination & Treatment: I hereby authorize Dr. Vijaya Dasari and North Texas Gastroenterology, P.A. to examine me and furnish diagnostic and therapeutic services deemed medically necessary. I consent to the submission of tissue/specimens to clinical pathology laboratories for analysis and billing to my insurance carrier.

2. Assignment of Benefits & Financial Policy: I assign all medical insurance benefits directly to North Texas Gastroenterology, P.A. for services rendered. I understand that I am financially responsible for all co-pays, deductibles, coinsurance, and non-covered services. In addition to physician fees, separate charges may apply from surgery centers/hospitals, pathology/biopsy labs, and anesthesia providers.

3. Cancellation & Rescheduling Fees:
• Office Appointments: A **$50 fee** is charged for cancellations made with less than 24 hours' notice or no-shows.
• Procedures: A **$150 fee** is charged for procedure cancellations or rescheduling without at least **5 business days' notice**.

4. HIPAA Privacy & Communication Permissions: I acknowledge receipt/review of the Notice of Privacy Practices. I authorize North Texas Gastroenterology, P.A. to disclose my protected health information for treatment, payment, and healthcare operations.

Permission to leave voicemail on primary phone? [ ] YES [ ] NO **Permission to communicate via email?** [ ] YES [ ] NO

Authorized Individuals to receive/discuss medical information or pick up records:

1. Name:	**Relationship:**	**Phone:**
2. Name:	**Relationship:**	**Phone:**

Do you have an Advance Directive? [ ] Living Will [ ] Medical Power of Attorney [ ] None

9. PATIENT ACKNOWLEDGMENT & SIGNATURE

I certify that I have reviewed this complete Pre-Colonoscopy Health History Packet and have answered all questions accurately to the best of my knowledge. I understand that false or incomplete medical history may increase risks associated with colonoscopy or sedation. I understand that my procedure may be canceled or delayed if bowel preparation is inadequate or if unmanaged health risks exist.

Patient Name (Printed):	**Date (MM/DD/YYYY):**
Patient / Guardian Signature:	**Relationship (if signed by Guardian):**

SUBMISSION INSTRUCTIONS:
Please return your completed packet along with a copy of your **Photo ID** and **Insurance Card(s)** via:
• **Email:** vjydasari123@gmail.com | • **Fax:** (940) 243-3554
• **In Person:** Denton Office (2701 Shoreline Dr., Suite 101) or Lewisville Office (560 W. Main St., Suite 106)