ALLIED
DIGESTIVE DISEASE CENTER
OF HOUSTON, PA
BABATUNDE ADEYEFA, M.D.

Patient Name: _____ DOB: _____

Phone #: _____ Mobile #: _____

Email: _____ Other: _____

Address: _____

Pharmacy Name _____ Pharmacy#: _____

Chief Complaint: _____

How did you hear about us? _____

Primary Care Physician Name and Number? _____

[redacted]

Insurance: _____ Member ID: _____

Group #: _____ Phone #: _____

Relationship to Insurer: _____ Other: _____

[redacted]

Insurance: _____ Member ID: _____

Group #: _____ Phone #: _____

Relationship to Insurer: _____ Other: _____

[redacted]

Insurance: _____ Member ID: _____

Group #: _____ Phone #: _____

Relationship to Insurer: _____ Other: _____

[redacted]

ALLIED
DIGESTIVE DISEASE CENTER
OF HOUSTON, PA
Ph.: 832-912-4481
Website: www.alliedgidoc.com

WELCOME

Policies and Procedures

Dear Patient:

Welcome to Allied Digestive Disease Center of Houston. Our goal is to provide you with excellent quality medical care. The following policies and procedures are in place to help make your visit more pleasant.
Please take time to review and initial these policies so you will have a clearer understanding of our mutual expectations.

____**Office Hours: Monday through Friday from 8:30am to 5:00pm.** We will be available during these hours for information, appointments and prescriptions. If you need assistance on nights or weekends, please call the office and the answering service will reach the physician on call. If you feel that you have an emergent situation, please call 911 for immediate assistance.

____**Prescription Refills:** Please call your pharmacy request refills and they will contact the office for approvals. Please allow us 24 hours to approve refills. Medications cannot be refilled over the weekend. Contact us on the weekday before you need your refill.

____**Appointments:** Please make every effort to make your appointment. If you cannot make your appointment, please call the office as soon as possible. We will make every effort to schedule your appointment at a convenient time for you. **Arrive 15 minutes early for check-in.** You will receive a reminder call and/or an email reminder on your appointment with arrival time.

____**Payments are due at the time services are rendered.** This includes applicable co-pays, co-insurance and deductibles as well as any outstanding balances, unless previous arrangements have been made. We accept cash, checks, and credit cards. Co-pays and co-insurance amounts are required at time of service per managed care contracts. If you have a deductible, we will ask for the "allowed" amount as per the insurance company agreement. We accept Medicare assignment.

If you have any questions, concerns or comments, please give us your feedback. We are hopeful we will exceed your expectations for excellent care and communication from the physician and staff.

I hereby acknowledge that I have been given a copy, reviewed, and agree to the Policy Practices of Dr. Babatunde Adeyefa at Allied Digestive Disease Center of Houston, P.A

_____ Printed Patient Name

_____ Signature of Patient or Responsible Party

_____ Responsible Party (if not patient)

_____ Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Dr.Adeyefa for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis and treatment of me by Dr.Adeyefa may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected for me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This is protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practices healthcare operations. The physicians are not required to agree to the restrictions that I may request, however if the physicians agree to a requested restriction, that restriction is binding on both the physician and the attending physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Adeyefa has taken action in relevance on this consent.

I understand I have a right to review the practices **Notice of Privacy Practices** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performance of healthcare operations of Gastroenterology Specialists. It also describes my rights and the physician's duties with respect to my protected health information.

Dr.Adeyefa reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize the practice to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize the practice to leave scheduling information on my answering machine, or voicemail system.

_____

Signature of Patient or Responsible Party

_____

Date

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DIGESTIVE DISEASE CENTER
OF HOUSTON, PA
ALLIED DIGESTIVE DISEASE CENTER OF HOUSTON, PA
21212 Northwest FWY STE 425-A CYPRESS TX 77429
Ph.: 832-912-4481
Website: www.alliedgidoc.com
BABATUNDE ADEYEFA, M.D.

RELEASE OF MEDICAL INFORMATION

We will need to access your private healthcare information for the purpose of treatment, payment, and operations. In using this information our office will comply with state and federal laws pertaining to your privacy rights, including HIPPA act. We will disclose your information only when sharing the information for the purpose of treatment, payment, and operation. This information may be shared with but is not limited to your primary care physician(s), referring physician(s), and specialist(s) who will be involved in your medical care treatment.

In order to obtain medical records from another physician or medical institution, or to provide medical records as stated above please sign below in acknowledgement of your consent.

Please specify a spouse, family member, friend, or physician(s) that we may release and request medical information or records to:

_____

Please sign below in acknowledgement that you have read, understood, and agree to the above stated policy

Patient Signature: _____

Patient Name (Print): _____ **Date:** _____

Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

Personal Health History			
Please check past or current problems or conditions			
Condition		Condition	
Hypertension		Seizures	
High cholesterol		Headaches	
Diabetes		Stroke	
Heart attack or angina		Prostate problem	
Irregular heart rhythm		Breast problem	
Congestive heart failure		Urinary tract infections	
Asthma		Osteoarthritis	
Emphysema or chronic bronchitis		Cancer (Please list type)	
Pneumonia		Thyroid problem	
Gastroesophageal reflux disease		Bleeding disorder	
Stomach ulcer		Addiction Issues	
Kidney problems		Depression or anxiety	
Liver disease/hepatitis		Mental Illness	
Colon cancer		Other (please describe)	
Bowel/digestive problem			

Previous Surgical Procedures	
Please check if you have had any of the following	
Procedure	Year
Heart surgery	
Carotid artery surgery	
Vascular surgery / stent	
Abdominal aneurysm repair	
Hysterectomy	
Gallbladder removed	
Appendix removed	
Tonsillectomy	
Joint replacement	
Breast cancer surgery	
Prostate cancer surgery	
Hernia	
Pacemaker	
Other (please describe)	

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: Single Married Divorced Widowed Life Partner
Education level: Did not Graduate High School Some College Bachelor's Degree Master's Degree or Higher
Occupation: Occupational concerns: Stress Hazardous substances Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? No Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
Hobbies:

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

Chest pain	Rectal bleeding	Eye pain	Nervousness
Shortness of breath	Black/tarry stools	Loss of vision	Pain in testicles
Wheezing	Weight loss	Double vision	Loss of libido
Cough	Weight gain	Memory loss	Impotence
Coughing up blood	Loss of appetite	Ringing in ears	Breast pain
Sore throat	Difficulty swallowing	Pain in ears	Breast discharge
Nasal congestion	Diarrhea	Nose bleeds	Other (please describe below)
Irregular heartbeat	Constipation	Hoarseness	
Fast heartbeat	Painful urination	Easy bleeding	
High blood pressure	Blood in urine	Easy bruising	
Low blood pressure	Urine frequency	Rash	
Lightheadedness	Decrease in urine flow	Changes in mole	
Dizziness/fainting	Urine leakage	Sore that won't heal	
Abdominal pain	Headache	Fatigue/lethargy	
Heartburn	Weakness	Insomnia	
Indigestion	Loss of strength	Forgetfulness	
Ankle swelling	Balance problems	Depression	
Nausea	Pain, weakness, or numbness in		
Vomiting	Arms Hips Back		
Vomiting blood	Legs Neck Shoulders		
Change in bowel habits	Hands Feet		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
Mental illness		Chemical dependency	
Celiac Disease		Diabetes	
Colon Cancer		Pancreatic Disease	
Colon Polyps		Ulcerative Colitis/Crohn's	
Heart Disease		Female Cancer (Breast, Ovarian,Uterine, or Endometrial)	

Allergies:

Please list any allergies to medications or foods

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:							
Please check whether you have had the following preventive services and enter the year of the service							
Immunizations			Year	Tests			Year
Tetanus vaccine / Tdap	Yes	No		Pap smear/pelvic	Yes	No	
Pneumonia vaccine	Yes	No		Mammogram	Yes	No	
Influenza vaccine	Yes	No		Bone dexa	Yes	No	
Shingles vaccine	Yes	No		Colonoscopy	Yes	No	
				Prostate test	Yes	No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
Eye doctor	Nephrologist
Cardiologist	Psychiatrist
Oncologist	Allergist
Urologist / Gynecologist	Vascular
Gastroenterologist	Pulmonologist
Endocrinologist	Other

Health Behaviors:					
Tobacco use: Never Quit (when)_____ Current smoker					
If current smoker how many packs per day for how many years_____					
Alcohol intake: No Yes If yes, more than 3 times per week? _____					
Illicit drug use (including marijuana, cocaine, steroids): Never Past Current					
If past or current drug use describe:					
Exposure to secondhand smoke	Yes	No	Do you have any piercings? Yes No		
Eat a diet high in fruits and vegetables	Yes	No	Do you have any tattoos?	Yes	No
Get 30 minutes of exercise 5 times a week	Yes	No	Have you traveled outside the US ? Yes No		

Advance Care Planning:		
Do currently have, or would you like information on, any of the following items		
Living Will:	Have	Don't Have
Durable Power of Attorney:	Have	Don't Have
DNR Order:	Have	Don't Have
Other:	Have	Don't Have

Urinary Incontinence Assessment				
In the Past few Weeks:				
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐

Mood Screening	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
Not at all	Not at all
Several days	Several days
More than half the days	More than half the days
Nearly every day	Nearly every day

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____