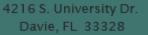


Visit Form

•					
	Full Name:				
•	Date of Birth:				
•	Gender: □ Male □ Female □ Other				
•	Address:				
•	City:	_ State:	ZIP Code:		
•	Phone Number:				
•	Email:				
•	Emergency Contact Name:		<u></u>		
•	Emergency Contact Phone Number:				
Insurance Information					
•	Primary Insurance Company:				
•	Policy Number:				
•	Group Number:				
•	Policyholder's Name:				
•	Relationship to Patient:				
•	Secondary Insurance (if applicable):	:			
Medical History					
•	Primary Care Physician:				
•	Referring Physician:				
•	Current Medications (Include dosage	e and freque	ency):		











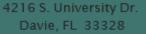






Allergies (Medications, foods, etc.):			
0	0		
•	0		
mptoms & Concerns	Symptoms & (
Reason for Visit:	• Reaso		
Describe Your Symptoms: (Check all that apply)	• Descri		
○ □ Abdominal Pain	0		
 □ Nausea/Vomiting 	0		
o □ Diarrhea	0		
 □ Constipation 	0		
○ □ Heartburn/Acid Reflux	0		
○ □ Blood in Stool	0		
 ○ □ Weight Loss 	0		
 □ Bloating 	0		
o □ Other:	0		
edical & Surgical History	Medical & Sur		
Have you been diagnosed with any of the following? (Check all that apply)			
 □ Irritable Bowel Syndrome (IBS) 	0		
 □ Inflammatory Bowel Disease (IBD) 	0		
 ○ □ Celiac Disease 	0		
 □ Gastroesophageal Reflux Disease (GERD) 	0		
 □ Liver Disease 	0		
o □ Peptic Ulcer Disease	0		
 □ Gallbladder Disease 	0		







Davie: 954-331-0104



954-378-9914







o □ Other:
Previous Surgeries: (Please list)
0
0
Lifestyle Factors
Smoking Status: □ Never □ Former □ Current
Alcohol Consumption: □ None □ Social □ Regular
Dietary Habits:
Exercise Frequency:
Family Medical History
• Do any of your family members have a history of gastrointestinal diseases? \square Yes \square No
o If yes, please specify:
Additional Information
 Any other concerns or information you would like to share with the doctor?
I authorize Broward Digestive Care, P.A. to release any medical information necessary to process my insurance claim. I permit a copy of this authorization to be used in place of the original. I authorize Broward Digestive Care, P.A. to apply for benefits for covered services rendered. I request that payment from my insurance company be made directly to Broward Digestive Care, P.A. I certify that the information reported regarding my insurance is correct. • Patient/Guardian Signature:



