BROWARD
DIGESTIVE CARE

Visit Form

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Address:** _____
- **City:** _____ **State:** _____ **ZIP Code:** _____
- **Phone Number:** _____
- **Email:** _____
- **Emergency Contact Name:** _____
- **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 and frequency):**
  - _____
  - _____

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- _____
- **Allergies (Medications, foods, etc.):**
  - _____
  - _____

Symptoms & Concerns

- **Reason for Visit:** _____
- **Describe Your Symptoms:** (Check all that apply)
  - ☐ Abdominal Pain
  - ☐ Nausea/Vomiting
  - ☐ Diarrhea
  - ☐ Constipation
  - ☐ Heartburn/Acid Reflux
  - ☐ Blood in Stool
  - ☐ Weight Loss
  - ☐ Bloating
  - ☐ Other: _____

Medical & Surgical History

- **Have you been diagnosed with any of the following?** (Check all that apply)
  - ☐ Irritable Bowel Syndrome (IBS)
  - ☐ Inflammatory Bowel Disease (IBD)
  - ☐ Celiac Disease
  - ☐ Gastroesophageal Reflux Disease (GERD)
  - ☐ Liver Disease
  - ☐ Peptic Ulcer Disease
  - ☐ Gallbladder Disease

- ☐ Other: _____

- **Previous Surgeries:** (Please list)
  - _____
  - _____

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?** ☐ Yes ☐ No
  - 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:** _____
- **Date:** _____