Dale Coy, MD
Manish Bhuva, MD
Dafna Gordon, MD
Amit Shah, MD
Chad Spangler, MD

GI PARTNERS of ILLINOIS, LLC

Brant Lutsi, MD
Nicole Gentile, MD
Erin Micklinghoff, CNP
James Ferguson, CNP
Katie Akers, CNP
Mary Joyce Lagatao, CNP

Last Name **First Name** **Middle Initial**

Address

City **State** **Zip Code**

Email Address **Marital Status**

Pharmacy Name/Town

Social Security Number: _____ - _____ - _____ **Date of Birth**: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Primary Care Physician: _____ **Cardiologist** _____

Patient's Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Name of Employer (Company Name) Occupation

HIPAA Contact Information

***Please list *YOUR* phone numbers below and checkmark where we may leave a confidential voicemail.**

Patients HOME: _____ ☐Voicemail

Patients WORK: _____ ☐Voicemail

Patients CELL: _____ ☐Voicemail

*** If we cannot contact you, may we leave medical information with another person?**

☐YES ☐NO

Their Name: _____

Relationship: _____ Phone: _____

***In case of emergency, who should we contact**: Same as person listed above ☐

Their Name: _____

Relationship: _____ Phone: _____

X Signature_____ **Date**_____

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REQUEST FOR RELEASE OF MEDICAL RECORDS
Complete Patient Information ONLY

Patient's Name (print) _____ Date of Birth _____

Patient's Signature _____ Today's Date _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

FOR OFFICE USE ONLY(DO NOT FILL OUT)

_____ ***Please send my medical records to the following physician:***
_____ ***Please obtain my medical records from the following physician:***

Physician's Name (print) _____

Address _____

City _____ State _____ Zip _____

Physician's Phone Number _____ Fax _____

_____ ***Please provide a copy of my records to me by***:

_____ Faxing to me at fax #_____

_____ Mailing a paper copy to the address above

_____ Holding a paper copy for pick-up in your office

Barrington / Crystal lake (circle one)

Records Requested _____ Date Picked Up/Office _____

Records Exclusion *_____ Date Mailed/Faxed _____

THIS RELEASE IS VALID FOR ONE YEAR FROM THE DATE SIGNED.
The patient has the right to revoke this authorization in writing to the above office. Although this is a HIPAA compliant office, and every effort is made to safeguard the confidentiality of patient records, I hereby release Gastroenterology and Internal Medicine Specialists, S.C. from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in my medical records.
*Under some circumstances, a patient has the right to exclude parts of their records that pertain to HIV/AIDS, mental conditions, genetic testing, or any form of substance abuse unless directly related to the above Doctors' testing and treatment. 1/17/19

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Telephone-(847)382-4410
Fax-(847)382-4451

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____
MRN:_____ Date Of Birth:_____
Age:_____ Notes:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race
☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Patient Portal ☐ Patient declines to specify Other:_____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies
☐ Aspirin ☐ Penicillins ☐ fentanyl ☐ Sulfa (Sulfonamide Antibiotics) ☐ Propofol ☐ Versed
☐ latex gloves Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep A When:_____ ☐ Hep B When:_____ ☐ Influenza vaccine When:_____ ☐ Pneumonia Vaccine When:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____ ☐ Upper Endoscopy When:_____ ☐ Abdominal U/S When:_____ ☐ CT Abdomen w/o dye When:_____ ☐ OTHER When:_____

Past or Present Medical Conditions

☐ None

☐ C.O.P.D. When:_____ ☐ Asthma When:_____ ☐ Diabetes Mellitus When:_____ ☐ GERD When:_____ ☐ Hepatitis B When:_____ ☐ Hepatitis C When:_____

☐ IBS When:_____ ☐ Liver Disease When:_____ ☐ Pacemaker When:_____ ☐ Sleep apnea When:_____ ☐ HIV When:_____ ☐ Hypertension When:_____

☐ Ischemic Heart Disease When:_____ ☐ OTHER When:_____

Previous Procedures

☐ None

☐ Gallbladder removed When:_____ ☐ Pacemaker Atrial & Ventricular When:_____ ☐ Hysterectomy When:_____ ☐ Hernia Repair When:_____ ☐ Gastric By-Pass When:_____ ☐ OTHER When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union

☐ Unknown ☐ Other

Alcohol

☐ None

Type	Quantity	Number	Frequency

Caffeine

☐ None

Intake:_____

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Smoker, current status unknown

☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Drug Use

☐ None

Type	Quantity	Number	Frequency

Exercise

None

Type | Quantity | Number | Frequency

Family Medical History

No knowledge of family history

No family history of

Colitis, chronic Crohns

Colon cancer

Colon polyps

Diagnoses	Mother	Father	Sister	Brother	Son	Daughter
Family hx of esophageal cancer						
Family hx of colon cancer						
Family hx of colon polyps						
Family hx of cardiovascular disease						
Family hx of diabetes mellitus						
Family History of crohn's						
Other:						