Jordan & Associates
GASTROENTEROLOGY, P.A.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (DAYTIME) _____ MOBILE _____

HEIGHT _____ WEIGHT _____

DOB _____ PRIMARY CARE MD _____

INSURANCE CARRIER _____ MEMBER ID # _____

GROUP# _____ INSURED NAME _____ RELATIONSHIP _____

SOCIAL SECURITY NO. _____ INS. CUST. SERV. TEL# _____

LOCATION REQUESTED: _____ PHYSICIAN REQUESTED: _____

SELF-PAY _____ NO INSURANCE _____

WHO ARE WE ALLOWED TO CONTACT IN THE EVENT YOU ARE UNAVAILABLE?

_____

RE: PROCEDURE CONFIRMATION & HIPPA COMPLIANCE

Please list any active medical problems. _____

_____

_____

Please list all medications (include over the counter products) _____

_____

_____

It is important that patients 65 and older have a history and physical on file with their primary care physician within 30 days of their Open Access Colonoscopy. This can be easily obtained through your primary care provider. Have you met that criteria?

Yes / No Date of exam _____ MD: _____

Do you take blood thinning medication? (coumadin, aspirin, or plavix) Yes / No

Do you have any allergies to medications? Yes / No please list _____

Please circle Yes or No in answer to the following medical history questions.

Heart Disease
Yes/No Coronary Artery Disease/angina/heart attack
Yes/No Congestive Heart Failure
Yes/No Valvular Heart Disease/Artificial Heart Valve

Lung Disease
Yes / No Emphysema, COPD, Asthma, or Bronchitis requiring regular medical therapy
Yes / No Sleep Apnea

General Health
Yes / No Kidney Disease
Yes / No Stroke
Yes / No Diabetes
Yes / No Do you take antibiotics when going for dental work?
Yes / No Have you had a joint replacement within the last year?
Yes / No Have you ever had a complication with anesthesia?
Yes / No Do you weigh more than 350 pounds?
Yes / No Do you currently take a weight loss medicine or supplement?

Gastroenterology
Yes / No Do you have heartburn more than twice a week?
Yes / No Do you see blood in your bowel movements?
Yes / No Do you have frequent constipation or diarrhea?
Yes / No Do you have relatives with colon cancer? Who? _____
Yes / No Have you ever had a colonoscopy? If yes, when? _____

Please return this completed form to our office. If there are no contraindications you will be assigned to our physician for a colonoscopy. You may need a preliminary appointment if there are medical concerns identified that would need attention before scheduling your colonoscopy. Your insurance company will be notified for benefit verification. We will contact you within 10 days of receipt of this form. If you have not heard from our office within 10 days please call (919) 938-4404 and ask for the Open Access Triage Coordinator.

Mail To: OPEN-ACCESS COLONOSCOPY AT JAG
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649 Guy Rd. Clayton, NC 27520
FAX: OPEN-ACCESS COLONOSCOPY- (919) 938-3055
EMAIL: OPEN-ACCESS@JORDANGI.COM