ADVANCED GASTROENTEROLOGY & ENDOSCOPY, P.C.
ALI S. KARAKURUM, MD, FACP, FACG

DATE_________________ SOC. SEC. NUMBER______________

FULL NAME____ DATE OF BIRTH____________________

ADDRESS: STREET____

TOWN____ STATE ______ ZIP ______________________

PHONE: HOME ______________________ WORK_______________________ CELL __________________

EMPLOYER ____ OCCUPATION _____________________

ADDRESS ____

EMERGENCY CONTACT: NAME ____

RELATIONSHIP ___________________________________ PHONE __________________________________

PRIMARY INSURANCE INFORMATION:

PROVIDER NAME ___________________________________ DEDUCTIBLE AMOUNT_________________

INSURED NAME ___________________________ INSURED SS# _____________________ DOB _________

INSURANCE ID# ____ GROUP# _______________________

RELATIONSHIP TO PATIENT ________________________________ COPAY AMOUNT _______________

SECONDARY INSURANCE INFORMATION:

PROVIDER NAME ____

INSURED NAME ___________________________ INSURED SS# _____________________ DOB _________

INSURANCE ID# ____ GROUP# _______________________

RELATIONSHIP TO PATIENT ________________________________ COPAY AMOUNT _______________

REFERRING PHYSICIAN __________________________PRIMARY CARE PHYSICIAN ________________

ADDRESS ____PHONE# _______________________

I understand that I am personally responsible for all fees incurred for the medical services rendered, regardless of my possessing any medical insurance coverage or any existing agreement between the Physician and such insurance company regarding fees, methods of payment or handling of claims. I request that the payment of benefits be made on my behalf to Dr. Ali S. Karakurum for services rendered by him. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefit or benefits payable for related services.

PATIENT/GUARANTOR SIGNATURE _________________________________ DATE ________________

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Patient Health Information Form

NAME: ____TODAY'S DATE: _____________ DOB _____________

REASON FOR TODAY'S VISIT:____

MEDICATION ALLERGIES:____

PAST MEDICAL HISTORY:

o Anemia o Asthma o Atrial fibrillation o Breast Cancer o Chronic Lung Disease
o Cirrhosis o Colitis o Colon Cancer o Colon polyps o Crohn's Disease
o Depression o Diabetes o Diverticulitis o Diverticulosis o Fatty Liver
o Gallstones o Glaucoma o Hemorrhoids o Heart attack o Hepatitis B o Hepatitis C
o Hiatal hernia o High blood Pressure o History of suicide attempt o HIV o Irritable Bowel syndrome
o Lactose intolerance o Liver Disease o Osteoporosis o Pancreatitis o Stroke
o Tuberculosis o Ulcer o Ulcerative colitis o NONE o Other ___________________________

PAST SURGICAL HISTORY:

o Appendectomy o Breast o C-Section o Cardiac Surgery o Cardiac Defibrillator/Pacemaker
o Cardiac Stent o Colon Resection o Colonoscopy o EGD/Upper endoscopy o ERCP
o Gallbladder o Hernia o Hemorrhoids o Hysterectomy o Liver biopsy
o Obesity Surgery o Stomach o Knee/Hip Replacement o Metallic Valve Placement
o NONE o Other surgery___________________________________

SOCIAL HISTORY:

o **Status** o Single o Married o Domestic partnership o Divorced o Separated o Widowed

o **Race** o Caucasian o African American o Hispanic/Latino o Asian o Other ____________

o **Gender** Male____ Female______ o Ethnicity If not American,___________

o **Smoker** _____ Pack Per Day ______Years o Non-Smoker

o **Alcohol** o Socially o Regularly o Do Not Drink ____________Amount per day

o **Caffeine** o Yes o No ______Amount per day

o **Occupation** _______________________________ o Working o Retired

Sleep: o Difficulty Falling Asleep o Snoring o Daytime Drowsiness
o Continuity Disturbances o Early Morning Awakening
o Sleep Apnea o Other

Blood Transfusion: o Yes o No

Tattoos: o Yes o No

Illicit Drugs: o Yes o No

FAMILY HISTORY:

o Family history not known o Adopted

Mother	o Alive	o Passed away	o Colon cancer or polyps	o Other	Age:_______
Father	o Alive	o Passed away	o Colon cancer or polyps	o Other	Age:_______
Sibling(s)	o Alive	o Passed away	o Colon cancer or polyps	o Other	Age:_______

Do you have a family history of colon cancer and/or polyps? o Yes o No

If yes, who: ______________________________ Type of Cancer: ____________________ Age Diagnosed:_______

REVIEW OF SYSTEMS:

Gastrointestinal tract:

o Abdominal pain o Anal / Rectal pain o Belching o Black stools o Bloating o Blood in stool

o Change in bowel habits o Constipation o Dairy intolerance o Diarrhea o Difficulty swallowing

o Flatulence o Heartburn o Hemorrhoids o Mucous in stool o Nausea o Vomiting

o Painful bowel movement o Rectal bleeding o Soiling stool / Incontinence o Weight Loss (unintentional)

Cardiovascular:

o Chest pain o Heart murmur o Palpitation o Shortness of breath

Constitutional:

o Chills o Fatigue o Fever o Loss of appetite o Night sweats o Weight gain o Weight loss

Ear-Nose-Throat:

o Hoarseness o Sore throat o Nose bleed

Hematological:

o Easy bruising o Prolonged bleeding o Swollen glands

Respiratory:

o Cough o Difficulty breathing

Psychiatric:

o Depression o Anxiety o Suicidal thoughts

Genito-Urinary:

o Pain with urination o Frequent urination o Urinary incontinence o Sexually Transmitted Disease

o Blood in urine o Heavy menstruation

Skin:

o Dry skin o Itching o Rashes o Suspicious lesions

Neurological:

o Dizziness o Fainting spells o Frequent Headaches o Memory Disturbance o Numbness

Endocrine:

o Cold intolerance o Excessive thirst o Hair change

Musculoskeletal:

o Muscle ache o Back pain o Joint pain

Signature___________________________

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HIPAA NOTICE OF PATIENT PRIVACY

By my signature below I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the practice will use and disclose my health information for purposes of treatment, obtaining payment for services rendered to me, and conducting health care operations. I have also been advised of my rights to obtain access to and control my Protected Health Information

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Select **ONE** of the following options in case we need to contact to you about your health:

☐ I authorize the office to leave a message with detailed information regarding my health.

OR

☐ I authorize the office to leave a message with a call-back number only, and wait for me to call to disclose any information regarding my health.

Number you would like us to call regarding your health: ________________

Name of person or class of persons to whom the office may disclose my health information:

____
____
____
____
____
____

____
Signature of Patient or of Personal Representative or parent/guardian

RECORD RELEASE AUTHORIZATION

Patient's Name ______________________________________

Address ____

____

Date of Birth _______________

Signature____

Date____

I hereby authorize and request full release of my complete medical record to:

Physician's Name:

ALI S. KARAKURUM, M.D. FACP, FACG

ADVANCED GASTROENTEROLOGY & ENDOSCOPY, P.C.

Address:	70 N. Country Rd., Suite 201 Port Jefferson, NY 11777
Tel:	(631) 331-0200
Fax:	(631) 331-0202
Website:	www.alikarakurum.com

Date___________________

ADVANCED GASTROENTEROLOGY & ENDOSCOPY, P.C.

PATIENT NAME:________________________________

ALI S. KARAKURUM, M.D., FACP, FACG

70 N. Country Rd., Suite 201 | www.alikarakurum.com | Tel: (631) 331-0200
Port Jefferson, NY 11777 | 1-888-GASTRO-1 | Fax: (631) 331-0202

Medications	Dosage	Frequency	Start Date	Stop Date

PLEASE LIST ALL ALLERGIES:	