COLONOSCOPY/UPPER ENDOSCOPY QUESTIONNAIRE

Save this form to the desktop before completing it,
then email to schedule@cohengastro.com or fax to 312-695-4453

Date: _____

Last Name: _____ First Name: _____ Gender: _____

DOB: _____ Age: _____ Primary Doctor: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Your Pharmacy: _____

Insurance Carrier: _____

Credit Card Number: _____ Expiration Date: _____

A FEE WILL BE CHARGED FOR CANCELLATIONS OR RESCHEDULING WITHIN 3 BUSINESS DAYS OF YOUR PROCEDURE

1) Procedure you need: ☐ Upper Endoscopy (EGD) ☐ Colonoscopy ☐ Flexible Sigmoidoscopy

2) Why do you need this test (e.g. screening, symptoms) _____

3) Please check the boxes for any of the following blood thinning medications that you take:

☐ Aspirin ☐ Plavix (clopidogrel) ☐ Persantine (dipyridamole) ☐ Brilanta (ticagrelor)
☐ Effient (prasugrel) ☐ Coumadin (warfarin) ☐ Lovenox (enoxaparin) ☐ Eliquis (apixaban)
☐ Xarelto (rivaroxaban) ☐ Pradaxa (dabigatran) ☐ Savaysa (edoxaban)

4) Please list all other medications you are currently taking (doses are not necessary):

_____

_____

5) Do you have any medication allergies (if so please list) _____ ☐ Yes ☐ No

6) Please list your medical problems and surgical history including any abdominal surgeries:

_____

_____

7) Do you have diabetes? _____ ☐ Yes ☐ No

8) Do you have a pacemaker or implantable defibrillator? _____ ☐ Yes ☐ No

9) Are you constipated or have you had a prior poor quality colonoscopy prep? _____ ☐ Yes ☐ No

10) Have you had rectal bleeding? _____ ☐ Yes ☐ No

11) Have you ever previously had (check if yes) ☐ upper endoscopy or ☐ colonoscopy ____ ☐ Yes ☐ No

If yes, describe any abnormal findings: _____

12) Do you have any family history of (check if yes) ☐ colon cancer or ☐ colon polyps _____ ☐ Yes ☐ No

If yes, please list the relative(s) and approximate age of diagnosis (over or under age 60):

_____

13) Have you ever had either (check if yes) ☐ colon cancer or ☐ colon polyps _____ ☐ Yes ☐ No

If yes, what year(s)? _____

GREG S. COHEN MD LLC

Authorization to Retain a Credit Card on File

Patient Name: _____ Date of Birth: _____

The purpose of this form is to authorize Greg S Cohen MD LLC to retain a valid credit card number on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. Dr. Cohen reserves the right to charge the credit card listed below monthly for all current patient balances under $900.00 including co-pays, deductibles, co-insurance, and charges not allowed by your insurance company. A receipt will be sent to your current address on file or emailed if you provide a valid email address. This notice serves as your consent to being charged for all current patient balances per above on your account. A representative from Dr. Cohen's office will contact you regarding balances over this amount either via a phone call, email, or statement.

2. Other than the conditions mentioned above, under NO circumstance will Dr. Cohen's office charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be confidentially kept within our secure credit card program. Once your information is entered into the system no one will be able to access your full credit card number or CVV information.

Acknowledged, Agreed & Accepted:

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my Authorization and consent to providing the requested information for my credit card to be charged Accordingly for the conditions listed above.

X_____ X_____
Patient Signature Date

X_____ X_____
Staff Signature Date

NAME AS IT APPEARS ON CREDIT CARD: _____
BILLING ADDRESS: _____

Please provide your card to the receptionist, she will enter the information into our secure system and return the card to you. No physical copy of your credit card # or CVV will be maintained in the office.

_____

Only Sign Below to Indicate Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with Dr. Cohen's office, Dr. Cohen's office will require prepayment of any estimated patient responsibility after your insurance pays or full fee if you have no insurance coverage. You also agree to pay any remaining balances due after prepayment and insurance payment within 30 days.

X_____ X_____
Patient Signature Date

X_____ X_____
Staff Signature Date