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: _____

Address: _____

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.

For information on insurance accepted by our office and complete details about what you may owe after your visit, including information about our out of network status for Medicare and Blue Cross Blue Shield, see: www.cohengastro.com/billing-and-insurance

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.

Initial below **only** to decline storing a credit card on file:

_____ Decline to Retain a Credit Card on File:
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 the full fee for rendered services. If you have insurance, a claim will be filed on your behalf and you will be refunded any amount paid by insurance for the rendered services.

Acknowledged, Agreed & Accepted:
Having read this form and talked with the staff, unless otherwise indicated by initialing above, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged according to the conditions listed above.
No physical copy of your credit card number or CVV will be maintained in the office.

X_____
Patient Signature

X_____
Date