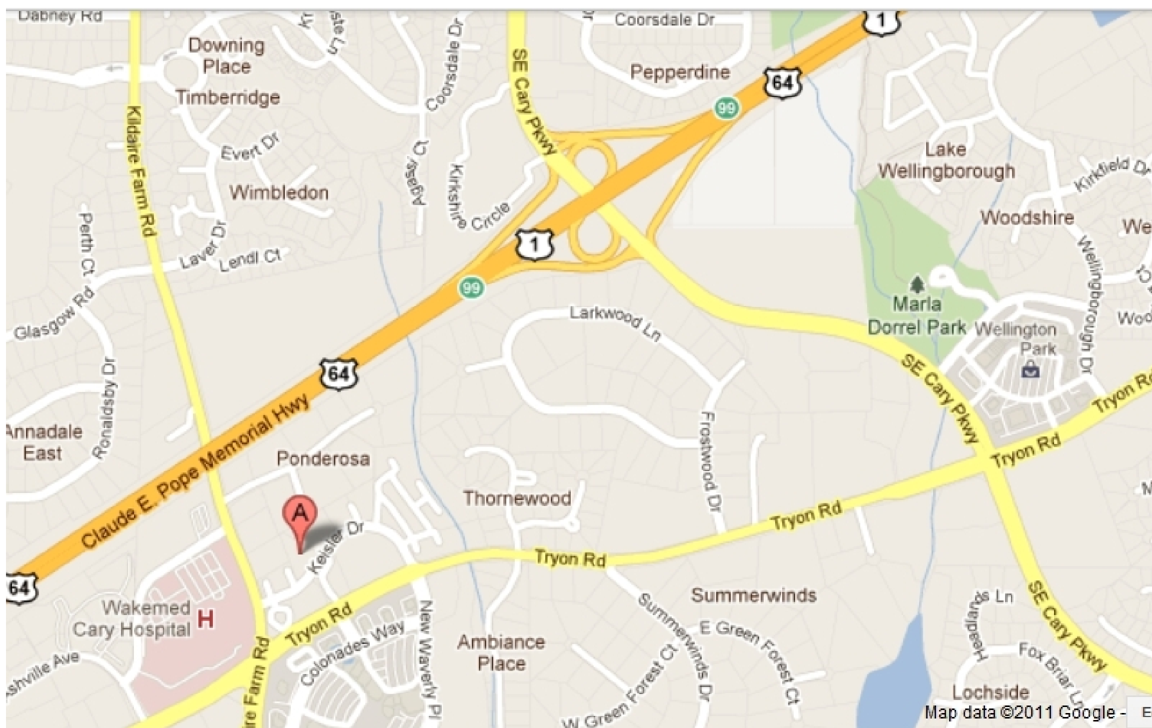
DOUGLAS B. PRITCHETT, M.D.
CARY DIGESTIVE DISEASES, PLLC
251 KEISLER DRIVE, STE. 201
CARY, NC 27518
(919) 854-5630 Fax (919) 854-5632
www.carydigestivediseases.com

Please take a few minutes to fill out the enclosed forms prior to your appointment. Also, ask your physician to send us any information or test results he/she has related to the reason for which you are coming in. This information will assist us in providing you with the best possible care. Be sure to bring your current insurance information with you so that we can file a claim to your insurance company, as well as any co-pay that may be due. We also request that you bring in your medications. This will include your prescription medications as well as your over-the-counter supplements. We prefer that you bring the bottles in, however if you choose to bring in a list please make sure it contains the medication name, dosage amount, and how many times a day you take it. A map is below to assist you in finding us. Call us should you have any questions prior to your appointment. Our phone number is 919-854-5630.



Douglas B. Pritchett, M.D.
Cary Digestive Diseases, PLLC
Patient Information

PLEASE PRINT Date____/____/____

Patient's Full Name____
Last First Middle

Home Address ____
Street City State Zip Code

Phone: Home______________________ Work______________________ ext ________ Cell ______________________

If you have an answering machine or voice mail can we leave messages? Yes No (please circle)

Date of Birth _____/_____/_____ Social Security #__ __ __-__ __-__ __ __ __ Sex: Male Female

Marital Status: Single Married Divorced Separated Widowed Occupation ____________________________

Primary Care Doctor _______________________________ Name of Practice __________________________________

INSURANCE INFORMATION
Please bring your insurance card(s) with you to your appointment.

PRIMARY INSURANCE ____________________ Policy # _________________________ Group #________________

Address ____ City __________________ State _______ Zip ____________

Policy Holder (if not patient)____ Relationship to patient _______________
Last First Middle

Insured's Date of Birth ____/____/____ Social Security #__ __ __-__ __-__ __ __ __ Sex: Male Female

Insured's Employer _______________________________________ Work Phone ________________ ext______

Employer's Address ____
Street City State Zip Code

SECONDARY INSURANCE __________________ Policy # _________________________ Group #_______________

Address ____ City __________________ State _______ Zip ____________

Policy Holder (if not patient) ____ Relationship to patient _______________
Last First Middle

Insured's Date of Birth ____/____/____ Social Security #__ __ __-__ __-__ __ __ __ Sex: Male Female

Insured's Employer _______________________________________ Work Phone ________________ ext______

Employer's Address ____
Street City State Zip Code

I hereby authorize payment of medical benefits billed to my insurance to *Cary Digestive Diseases, PLLC*. I accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. I hereby authorize *Cary Digestive Diseases, PLLC* to release all information necessary to secure payments of said benefits.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

X____ ______________________
Signature of Patient or Personal Representative Date

Review of Systems

Please check if you have/had problems to the Areas indicated.

Patient Name: ________________________

Chart Number: ________________________

1. SYSTEMIC	**YES**	**NO**
Weight loss	☐	☐
Weight gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
2. EYES		
Blurred vision	☐	☐
Double vision	☐	☐
Spots before eyes	☐	☐
3. EARS, NOSE & THROAT		
Loss of hearing	☐	☐
Sinus problems	☐	☐
Earaches	☐	☐
Ringing in ears	☐	☐
Difficulty swallowing	☐	☐
Frequent sore throat	☐	☐
4. LUNGS		
Chronic cough	☐	☐
Coughing up blood	☐	☐
Shortness of breath	☐	☐
Breathing difficulty	☐	☐
Wheezing	☐	☐
5. HEART		
Chest pain	☐	☐
Race/skipping heart beats	☐	☐
Palpitations	☐	☐
6. GASTROINTESTINAL		
Loss of/excessive appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Indigestion/heartburn	☐	☐
Bloody stool	☐	☐
Change in bowel habits	☐	☐
Black or tarry stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas/bloating	☐	☐
Lactose intolerance	☐	☐
Other food intolerance	☐	☐
7. LYMPH NODES		
Skin discoloration	☐	☐
Enlarged nodes	☐	☐
Abdominal bruising	☐	☐

8. GENITOURINARY	**YES**	**NO**
Urinary frequency	☐	☐
Urgency	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Inability to control bladder	☐	☐
9. MUSCLE/SKELETAL		
Joint swelling	☐	☐
Stiffness	☐	☐
Joint pain	☐	☐
Back pain	☐	☐
Loss of strength	☐	☐
10. SKIN/BREAST		
Rash	☐	☐
Lesions/moles	☐	☐
Itching	☐	☐
Discoloration	☐	☐
Breast pain	☐	☐
Discharge from nipples	☐	☐
Breast lump	☐	☐
11. NERVOUS SYSTEM		
Headaches	☐	☐
Poor balance	☐	☐
Memory loss	☐	☐
Tremors	☐	☐
Numbness	☐	☐
Seizures	☐	☐
12. PSYCHIATRIC		
Anxiety	☐	☐
Fear	☐	☐
Depression	☐	☐
Difficulty concentrating	☐	☐
Thoughts of suicide	☐	☐
Thoughts of violence	☐	☐
13. ENDOCRINE		
Excessive thirst	☐	☐
Excessive hunger	☐	☐
Excessive urination	☐	☐
Heat/cold intolerance	☐	☐

Date Reviewed__________ **By** ________________

Date Physician Signature

Douglas B. Pritchett, M.D.
Cary Digestive Diseases, PLLC
Patient Health History Form

Name ____ Date_______________________

Present Problem ____

Preferred Pharmacy and Phone Number ____

Past Surgeries (Include Dates)____
____
____

Medical History (check if applicable)

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma/Wheezing
- ☐ Cancer
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes – insulin/oral meds
- ☐ Diverticulitis/Diverticulosis
- ☐ Free Bleeder
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Heart Valve Replace
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Insomnia
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Oxygen
- ☐ Pacemaker
- ☐ Peptic Ulcers
- ☐ Seizures
- ☐ Sleep Apnea (CPAP y/n)
- ☐ Stents/Pacemaker/Defib
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis

Women only – Are you pregnant or currently planning pregnancy? ☐ Yes ☐ No

Last Aspirin Dosage __________________ Are you on Coumadin/blood thinners? ☐ Yes ☐ No

Do you Smoke? ☐ No ☐ Yes _____packs/day Do you drink alcohol? ☐ No ☐ Yes

Family History	**Age Now or at Death**	**Check if Living**	**Chronic Illness or Cause of Death**
Mother	__________________	☐	____________________________
Father	__________________	☐	____________________________
Mother's Mother	__________________	☐	____________________________
Mother's Father	__________________	☐	____________________________
Father's Mother	__________________	☐	____________________________
Father's Father	__________________	☐	____________________________
Brother/Sister	__________________	☐	____________________________
Brother/Sister	__________________	☐	____________________________
Children	__________________	☐	____________________________
Children	__________________	☐	____________________________

Is there a family history of Colon Cancer? ☐ Yes ☐ No Relation to you _______________________
Is there a family history of Colon Polyps? ☐ Yes ☐ No Relation to you _______________________

Nurse to Complete: Weight __________ lbs. BP_____/_____ Pulse _______ Resp. _______ Temp._______F.

DOUGLAS B. PRITCHETT, MD
CARY DIGESTIVE DISEASES, PLLC
MEDICATION LIST

PATIENT NAME: ____________________________ DATE OF BIRTH __________________

DATE: ________________________ LATEX ALLERGY? YES NO (please circle)

DRUG ALLERGIES: ____

____

Please list your prescription medications as well as any over-the-counter medications you take (vitamins, supplements, pain relievers, etc.)

MEDICINE NAME	**DOSAGE**	**HOW DO YOU TAKE IT** How many times a day / am or pm

DOUGLAS B. PRITCHETT, M.D.
CARY DIGESTIVE DISEASES, PLLC
251 KEISLER DRIVE, STE. 201
CARY, NC 27518
(919) 854-5630

REGISTRATION AGREEMENT

Patient Name: ____________________________ Date of Birth:_______________

In order to better serve your needs and clarify any questions that you may have regarding your insurance and our office policies, we have adopted the following **Registration Agreement**. Signing this agreement indicates that you have read it carefully and that you agree to the following conditions:

1. We are committed to providing you with the best possible care. As a service to you, we will gladly file your insurance claim. However, we must have a copy of your current insurance card in order to file. At the time of service, you will be responsible for any co-pays, deductibles, and any co-insurance amounts. All insurance changes must be given to us at the time information is correct and current.

2. We will file your secondary insurance provided all the information is given at the time of service.

3. Please remember that your contract is between you and your insurance company to provide reimbursement for medical care. We cannot be responsible for unwarranted delays by your insurance company or HMO. If your coverage is not what you expect, please discuss this with your insurance company or your employer.

4. Any outstanding balances after insurance pays or denies will be billed to you for payment. All patient balances become due and payable immediately upon receipt of our statement.

5. A $25.00 service charge will be applied to your account for all returned checks.

6. Medical Records Request – If you require a copy of your medical records, you must sign a Medical Records Release of Information form and a minimum payment of $10.00 will be required.

7. In the event that an unpaid balance exceeds 90 days in arrears, collection action may be taken. This may include transfer to a collection agency.

8. Any changes to the above agreement must be received in writing and signed by the office manager or his/her representative.

____ _______________
Patient Signature or Responsible Party Date

Relationship to patient (if signed by a personal representative of patient): ____________________

DOUGLAS B. PRITCHETT, M.D.
CARY DIGESTIVE DISEASES, PLLC
251 KEISLER DRIVE, STE 201
CARY, NC 27518
(919) 854-5630

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name:_________________________________ Date of Birth:_________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

____ _______________________
Patient Signature or Responsible Party Date

Relationship to patient (if signed by a personal representative of patient): ___________________________

AUTHORIZATION FOR RELEASE OF INFORMATION
Please initial and write the name(s) below, if applicable

_____ I authorize the release of information (ex: health information, appointment reminders, financial, billing, procedure estimates, etc). to the following individuals (ex. Spouse/Family Member/Friend). Name and Relationship **(PLEASE WRITE NAME AND RELATIONSHIP BELOW)**:
____