PROVIDENCE GASTROENTEROLOGY
Designated Patient-Centered Specialty Practice
26850 Providence Parkway, Suite 350, Novi, MI 48374
22250 Providence Drive, Suite 703, Southfield, MI 48075

LAURENCE E. STAWICK, M.D., A.G.A.F.
MARK S. DeVORE, M.D., F.A.C.P.
JULIA S. GREER, M.D.
KHA H. NGO, D.O.
SERGE A. SORSER, M.D.
Phone (248) 662-4110 Fax (248) 662-4120
Phone (248) 569-1770 Fax (248) 443-2439

PATIENT INFORMATION

Last Name: _____ First: _____ MI: ___ (use Driver's License name only)

Address: _____ City, _____ MI _____, Zip _____

Sex: ____ Cell: _____ Home Phone: _____ Work Phone: _____

DOB: _____ SSN: _____ Marital Status: _____ Legal Guardian: ☐ Yes ☐ N/A

Email: _____ **Race:** ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Language:** ☐ English ☐ Japanese ☐ Russian ☐ Other _____

INSURANCE

Primary Insurance: _____ Phone #: _____ Effective: _____

ID#: _____ Group: _____ Pre-Auth #: _____

Insured Name: _____ DOB: _____ SSN: _____ Copay: _____

☐ Retired ☐ Full Time ☐ Part Time Employer Name: _____

Employer Address: _____ Occupation: _____

Secondary Insurance: _____ Phone #: _____ Effective: _____

ID#: _____ Group: _____ Pre-Auth #: _____

Insured Name: _____ DOB: _____ SSN: _____ Copay: _____

PRIMARY CARE / INTERNAL MEDICINE PHYSICIAN

Name: _____ Phone: _____ Fax: _____

I hereby give my permission to my doctor to release medical information to my referring physician.

EMERGENCY CONTACT

Name: _____ Daytime Phone: _____

CARDIAC INFORMATION

Full name of Cardiologist: _____ Phone: _____ Fax: _____

YES	NO	PLEASE correctly ANSWER YES OR NO: ****IMPORTANT personal HISTORY****
		IN THE LAST 3 MONTHS have you had a Heart Attack, Stroke, or Congestive Heart Failure? (If yes, BOARD @ HOSPITAL)
		Do you have an Implanted Cardiac Defibrillator or Pacemaker? (If yes, BOARD @ HOSPITAL)
		Do you weigh over 350 pounds? (If yes, BOARD @ HOSPITAL)
		Do you use oxygen or C-PAP machine at home? (IF PT USES ANY OXYGEN, BOARD @ HOSPITAL)
		Are you on dialysis? (If yes, BOARD @ HOSPITAL)
		Do you use a wheelchair? If yes, ask; can you transfer yourself to a bed without assistance? (If No to 2nd? BOARD @ HOSPITAL)
		Have you or any family member had problems with anesthesia in the past?
		Do you see a heart doctor on a regular basis? (Reason) ***need cardiologist name above***
		Do you experience chest pain at rest? Do you experience chest pain unrelieved by Nitroglycerin tablets?
		Are you taking diet pills, not limited to but including Phen-Phen or Phenteramine? (Stop 2 weeks before any elective surgery)

I hereby authorize payment of medical benefits billed to my insurance to my doctor. I hereby 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 authorize the release of pertinent medical information needed to determine benefits for related services to insurance companies and their agents. I agree to pay all co-payments for office visits at the time the service. I will pay by cash, check, Visa or Master Card.

X_____ Date: _____

Signature of patient or guardian