GASTROENTEROLOGY ASSOCIATES OF WESTERN MICHIGAN PLC

2093 Health Drive SW, Suite 201
Wyoming, MI 49519
P: 616-452-7099
F: 616-452-4142
https://gastroassocwm.com

Allan Coates, DO
Katherine Baker, FNP
Julia Valdespina, FNP
Sharyn Coates, Dr. O.T.

Date: _____

Personal Information			
FIRST NAME	**M.I.**	**LAST NAME**	**FORMER NAMES**

DATE OF BIRTH	**GENDER**	**SOCIAL SECURITY NO.**
_____ / _____ / _____	□ Female □ Male	_____ - _____ - _____

PRIMARY CARE PHYSICIAN

Contact Information			
ADDRESS	**CITY**	**STATE**	**ZIP**

PHONE (Check Preferred Number)		
□ Home: (____) ____-_____	□ Cell: (____) ____-_____	□ Work: (____) ____-_____

EMAIL

Insurance		
INSURANCE COMPANY	**CONTRACT NO.**	**GROUP NO.**

NAME OF CARD HOLDER	**CARD HOLDER DATE OF BIRTH**

2nd INSURANCE COMPANY	**CONTRACT NO.**	**GROUP NO.**

NAME OF CARD HOLDER	**CARD HOLDER DATE OF BIRTH**

By signing this document I authorize payment directly to Gastroenterology Associates of Western Michigan PLC for medical services. I understand that I will be responsible for any balance not covered by my insurance company. I authorize the release of all information regarding my medical condition as necessary to process any insurance claims. I permit a copy of this to be used in place of the original. I also understand that by supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided.

Signature: _____ **Date:** _____

V1.2 Rev 12/4/2024

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Date: _____

First and Last Name: _____ **Date of Birth:** ____ / ____ / _____

Emergency Contact	
NAME	**RELATIONSHIP**
HOME PHONE	**CELL PHONE**

Demographics		
PREFERRED LANGUAGE □ English □ Spanish □ Other: _____	**RACE** □ American Indian □ Alaska Native □ Asian □ Unknown □ Refuse	□ White □ Black/African American □ Hawaiian Native/Pacific Islander □ Other: _____
ETHNICITY □ Hispanic or Latino □ Non-Hispanic or Latino □ Unknown □ Refuse		
MARITAL STATUS □ Single □ Married □ Widowed □ Divorced		

☐ Yes, I authorize Gastroenterology Associates of Western Michigan to contact me via text message to confirm my appointment or procedures. Please send the text confirmation to the following cell phone number: _____

☐ No, I do not authorize Gastroenterology Associates of Western Michigan to contact me via text message to confirm my appointment or procedures. Please call me.

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Date: _____

First and Last Name: _____ **Date of Birth:** ____ / ____ / _____

Chief Complaint
_____
_____
_____

Height:	**Weight:**

Family History	
CONDITION	**RELATIONSHIP**
Cancer (type if known): _____	
Colon Polyps	
GI Ulcer	
Liver Disease	
Pancreatitis	
Other: _____	

Current and Past Medical Conditions
_____
_____
_____
_____
_____
_____
_____

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Surgical Past

_____

_____

_____

_____

_____

_____

Medications

STRENGTH	DOSE	FREQUENCY

Preferred Pharmacy

Short Term:
Long Term:

Allergies

NAME	REACTION

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Gastroenterology		
MOST QUESTIONS CAN BE ANSWERED WITH YES OR NO	**YES**	**NO**
1. Do you have problems swallowing solids?		
2. Do you have problems swallowing liquids?		
3. Do you have heart burn? If yes, does it occur: □ At least daily □ More than twice a week □ Less than weekly		
4. Do you have reflux of stomach acid or bile?		
5. Does undigested food come up into your throat or mouth during the night without associated acid or bile?		
6. Do you have frequent nausea? If yes, does this usually result in vomiting? □ Yes □ No		
7. Do you ever vomit blood?		
8. Do you feel full early when eating a meal?		
9. Do you continue to feel full for a long time after a meal?		
10. Do you have abdominal pain that is *above* your navel?		
11. Do you have abdominal pain that is *at the level* of your navel?		
12. Do you have abdominal pain that is *below* your navel?		
13. How many days a week do you have bowel movements? _____		
14. Do you have frequent loose stools? If yes: How often do they occur? □ Every day of the week □ Only on somedays How many bowel movements do you have on a *good* day? _____ How many bowel movements do you have on a *bad* day? _____		
15. Do you have hard or lumpy stools?		
16. Do you have to strain to have a bowel movement?		
17. Do you ever see blood with your bowel movements?		
18. Do you ever lose control of your bowels? If yes, how often? □ Daily □ Weekly □ Monthly		
19. Do you have problems with bloating?		
20. Have you or anyone else noticed that your eyes or skin were yellow?		

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21. Have you ever been diagnosed with hepatitis? If yes, what was felt to be the cause? _____		

Date: _____

First and Last Name: _____ **Date of Birth:** ____ / ____ / _____

General Review of Systems

General	Yes	No
Fatigue	☐	☐
Weight change (not due to diet/exercise)	☐	☐

Other_____

Hematologic/ Lymphatic	Yes	No
Anemia	☐	☐
Platelet Disorder	☐	☐

Other_____

Cardiovascular	Yes	No
Chest Pain	☐	☐
Difficulty Breathing	☐	☐
Irregular Heart Beat	☐	☐
Swelling of legs	☐	☐

Other_____

Neurological	Yes	No
Dizziness	☐	☐
Seizures	☐	☐
Numbness	☐	☐
Headache	☐	☐
Stroke	☐	☐

Other_____

ENT	Yes	No
Chronic Ear Problems	☐	☐
Ringing in Ears	☐	☐
Mouth Sore	☐	☐

Other_____

Musculoskeletal	Yes	No
Muscle weakness	☐	☐
Muscle spasms	☐	☐
Joint Pain	☐	☐

Other_____

Endocrine	Yes	No
Hot flashes	☐	☐
Abnormal Thirst	☐	☐

Other_____

Respiratory	Yes	No
Wheezing	☐	☐
Chronic Cough	☐	☐
Shortness of Breath	☐	☐

Other_____

Genitourinary	Yes	No
Frequent Urination	☐	☐
Blood in Urine	☐	☐
Incontinence	☐	☐

Other_____

Gynecology	Yes	No
Abnormal Periods	☐	☐
Post-Menopausal	☐	☐
Hysterectomy	☐	☐

Other_____

Skin	Yes	No
Rash	☐	☐
Breast Mass	☐	☐

Other_____

Psychiatric	Yes	No
Depression	☐	☐
Anxiety	☐	☐
Bipolar	☐	☐
Schizophrenia	☐	☐

Other_____