GATEWAY GASTROENTEROLOGY INC.
OFFICE: (314) 529-4900
FAX: (314) 434-2679
WWW.GATEWAYGI.COM

Our office utilizes an electronic medical record. It is necessary to have your paperwork prior to your appointment. This paperwork is required for all patients regardless if you are already a patient with our practice. This system requires that all data be entered on every patient. Please fill out the enclosed pre-registration forms and mail or fax it back to our office 5 days prior to your appointment to 314-275-3704. If you fax your information, please bring the original documents with you.

If you are unable to mail or fax your paperwork back prior to your appointment, please arrive at least 30 minutes prior to your scheduled appointment so we may enter your health history information into your electronic medical record.

You will also need to bring your insurance card(s) and a photo id so our office so we can have a copy for our records. IF you have an insurance plan that requires referrals to see a specialist, please contact your primary care physician and ask that they request a referral authorization number from your insurance.

The doctors' office is located in St. Luke's Outpatient Center At 121 St. Luke's Center Drive, Building A, Suite 406, Chesterfield, MO 63017. It is on the west side of Highway 141/Woods Mill Road across from St. Luke's Hospital.

Please… help us out. If you are unable to keep your appointment, let us know AS SOON AS POSSIBLE – at least 48 hours ahead of time. Someone else will want to use this time.

If you have any questions regarding your visit, please feel free to contact our office.

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WELCOME

Dear Patient:

Welcome to Gateway Gastroenterology! We look forward to meeting you. We'd like to take this opportunity to tell you a little about our practice.

Gateway Gastroenterology is a group of eight board-certified gastroenterologists that was established in 1984. Our areas of expertise include the esophagus, stomach, small intestine, colon, liver, gallbladder, and pancreas. We offer a wide variety of gastroenterology services including inpatient and outpatient consultation as well as a broad range of endoscopic procedures including screening colonoscopy, upper endoscopy, testing for dietary intolerance, etc.

Our goal is to provide outstanding care in a timely, courteous, and professional manner. All of our physicians are committed to ongoing education and will make every effort to provide you with the most up to date and thorough care possible.

We will try hard to make your experience with us as hassle-free as possible. To this end, we will see you in a timely manner, return phone calls, and communicate with your other physicians.

Our practice includes Board Certified Nurse Practitioners who are specialized in gastroenterology and assist us in seeing patients in the office. Through their work, we are able to provide greater office time availability and flexibility. Our staff consists of friendly and knowledgeable people that are available to help with your scheduling, billing, and insurance needs.

We look forward to working with you.

Respectfully,

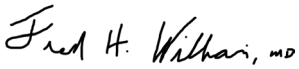

Jonathan C. Seccombe, M.D.


Jeffrey E. Matthews, M.D.


Andrew Y. Su, M.D.


Jeffrey T. Kreikemeier, M.D.


Brian C. McMorrow, M.D.


Fred H. Williams, M.D.


Richard T. Riegel, M.D.


Rajeev Ramgopal, M.D.


Cheri M. Carmody, A.N.P.


Kaitlin C. Doneff, A.G.N.P.

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PATIENT PORTAL

Gateway Gastroenterology has a Patient Portal for you to access some of your information. This portal shows any upcoming or previous appointments, some questionnaires for you to fill out prior to your appointments and you can also securely communicate with our office for questions to the doctor, nurse practitioner or staff.

You will get access to the Patient Portal once we have obtained your email address and have entered it into our practice management system. You will receive an email once we have enabled you to continue the registration process.

The web address: **https://health.healow.com/gatewaygi**

Please bookmark or save this to your Favorites.

Questionnaires – There are some questionnaires on this portal you can fill out instead of doing them in the paperwork we have sent you.

At this time the portal does not show your medications or any results.

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HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Primary Care M.D. ☐ OB/GYN ☐ Internet ☐ Friend/Family
☐ Advertisement ☐ Other _____

Name: _____ Sex: Male / Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Email Address: _____

Home Phone Number: _____ Alt. Contact Number: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Primary Care Physician: _____ Referring Physician: _____

The following is **required** by the State of Missouri (select one): ☐ Hispanic or Latino ☐ Neither Hispanic nor Latino

RACE ☐ White ☐ Black or African American ☐ American Indian ☐ Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Island ☐ Other not listed ☐ Multi-Racial (two or more races) ☐ Choose not to answer

Language Spoken: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: _____

Policy/Id Number: _____ Group Number: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

Secondary Insurance Company: _____ Phone Number: _____

Policy/Id Number: _____ Group Number: _____

Relationship to policy holder: _____ Policy Holder DOB: _____

POLICY HOLDER INFORMATION (IF OTHER THAN PATIENT)

Name: Mr/Mrs/Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Relationship to Patient: _____

Home Phone Number: _____ Alt. Contact Number: _____

Employer: _____ Occupation: _____

Responsible party/Guarantor's Signature: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

By providing the information I agree that Gateway Gastroenterology, Inc. or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service, leave a voice message on an answering device, send mail to my home address, or email notification regarding my care, our services, or my financial obligation. I hereby authorize the release of any medical information necessary to process my health insurance claims. I permit a copy of this authorization to be in place of the original. I have received a copy of Notice of Privacy Practices.

_____ _____

Signature Date

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MEDICATION RECONCILIATION FORM

For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below. Thank You!

Patient Name: _____

Date: _____ Date: _____

MEDICATION ALLERGIES AND REACTIONS

☐ Check if No Known Drug Allergies

_____

_____

MEDICATION LIST

Medication Name (Prescription Medications)	Dosage	Frequency (How Often)	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

List name(s) of any Over the Counter Medications/Herbal Supplements

1. _____
2. _____
3. _____

PHARMACY NAME

Local: _____ Phone Number: _____

Mail Order: _____ Phone Number: _____

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SYMPTOMS

Patient Name: _____ Date of Birth: _____ Date: _____

Constitutional Symptoms

Fever	N	Y
Chills	N	Y
Recent Weight Change	N	Y

Integumentary (Skin)

Rash	N	Y
Itching	N	Y
Change in skin color	N	Y
Reaction to sunlight	N	Y

Eye/Ears/Nose/Mouth/Throat

Blurred or double vision	N	Y
Visual loss	N	Y
Ringing of the ears	N	Y
Dizziness	N	Y
Hearing loss	N	Y

Hematologic/Lymphatic

Bleeding or bruising tendency	N	Y
Hemophilia	N	Y
Blood cancer	N	Y
Swollen lymph nodes	N	Y
Anemia	N	Y

Cardiovascular

Palpitation	N	Y
Loss of consciousness	N	Y
Heart trouble	N	Y
Shortness of breath with walking/lying flat	N	Y
Chest pain or angina pectoris	N	Y

Respiratory

Chronic or frequent cough	N	Y
Spitting up blood	N	Y
Asthma or wheezing	N	Y
Tuberculosis	N	Y
Shortness of breath	N	Y

Neurological

Stroke	N	Y
Convulsions or seizures	N	Y
Tremors	N	Y
Paralysis	N	Y

Genitourinary

Burning or painful urination	N	Y
Frequent urination	N	Y
Incontinence or dribbling	N	Y
Renal failure	N	Y
Blood in urine	N	Y

Musculoskeletal

Joint pain	N	Y
Joint stiffness or swelling	N	Y
Weakness of muscles	N	Y

Endocrine

Thyroid disease	N	Y
Diabetes	N	Y
Excessive thirst/appetite	N	Y

Psychiatric

Delusions	N	Y
Hallucinations	N	Y
Suicidal thoughts	N	Y

Allergic/Immunologic

Hives	N	Y
Chronic sinusitis	N	Y
History of anaphylaxis	N	Y

Reviewed By: _____ , MD Date: _____

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PATIENT HISTORY FORM

Patient Name: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY:

- ☐ GERD
- ☐ Barrett's Esophagus
- ☐ Schatzki's Ring
- ☐ Hiatal Hernia
- ☐ Esophageal Cancer
- ☐ Stomach Cancer
- ☐ Ulcers
- ☐ Celiac Sprue
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Colon Polyps/Colon Cancer
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Heart Disease/ Stents
- ☐ CHF
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Asthma
- ☐ COPD
- ☐ Anemia
- ☐ Seizures
- ☐ Migraines
- ☐ Sleep Apnea
- ☐ Hearing Loss
- ☐ Cancer _____

SURGERIES

_____

_____

_____

_____

HOSPITALIZATIONS OTHER THAN SURGERIES

_____

_____

_____

LAST COLONOSCOPY

Year: _____

LAST UPPER ENDOSCOPY

Year: _____

SMOKING

- ☐ Yes
- ☐ No

Pk/Yrs: _____

Yr Quit: _____

ALCOHOL

- ☐ Yes
- ☐ No

Drinks/day: _____

Yr Quit: _____

FAMILY HISTORY OF COLON CANCER?

- ☐ Yes If yes, who? _____
- ☐ No

FAMILY HISTORY OF POLYPS?

- ☐ Yes If yes, who? _____
- ☐ No

_____ _____

Patient's Signature Date

_____ _____

Nurse's Signature Date

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INFORMATION RELEASE

I _____ give consent for any medical information to be released to the following parties:

(Print Patient's Name Here)

INFORMATION TO BE RELEASED TO THE FOLLOWING PARTIES:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

It is the patient's responsibility to contact this office if any name listed above would need to be removed.
A new consent form would need to be filled out.

_____ _____

Patient Signature Date of Birth

_____

Date

_____

Witness