



GATEWAY GASTROENTEROLOGY INC.

OFFICE: (314) 529-4900

FAX: (314) 434-2679

WWW.GATEWAYGI.COM

This letter is to confirm your appointment on _____ at _____ with _____.

Our office is now using 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 new 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 at 314-275-3704 prior to your appointment. If you fax your information, please bring the original documents with you. You will also need to bring your insurance card(s) and a photo id so our office 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.

Currently, some of the required paperwork can be filled out on our Patient Portal. You can access the Patient Portal once we have obtained your email address. There is more information about our Patient Portal in this packet.

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.

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,



David Benage, M.D.



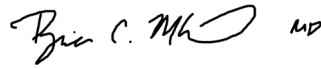
Jeffrey E. Matthews, M.D.



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.




Jonathan C. Seccombe, M.D.



Cheri M. Carmody, A.N.P.



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



Dianna J. Gaffner, A.N.P.



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.



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



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: _____

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: _____

PATIENT HISTORY FORM

Patient Name: _____

Date of Birth: _____

PERSONAL MEDICAL HISTORY:

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

SURGERIES

HOSPITALIZATIONS OTHER THAN SURGERIES

LAST COLONOSCOPY

Year: _____

LAST UPPER ENDOSCOPY

Year: _____

SMOKING

- Yes
 No

ALCOHOL

- Yes
 No

FAMILY HISTORY OF COLON CANCER?

- Yes If yes, who? _____
 No

FAMILY HISTORY OF POLYPS?

- Yes If yes, who? _____
 No

Pk/Yrs: _____ Drinks/day: _____

Yr Quit: _____ Yr Quit: _____

Patient's Signature

Date

Nurse's Signature

Date



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