Dr. Michael J. Rensch

Name:_____ Today's Date:_____

Social Security#_____ Date of birth:_____

Marital Status: Married Single Divorced Widowed Gender: Male Female

Home Address:_____ City:_____ State:_____Zip_

Phone# Home_____ Cell_____ Work_____

Email address:_____ **Preferred pharmacy**_____

Race: White American Indian Asian Black/African American Native Hawaiian/Pacific Islander
Other Declined

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Declined

_____

Employer:_____

Emergency Contact:_____ Phone_____

Primary insurance_____Policy#_____
Group#_____Phone#_____SS#_____
Name of insured & Relationship:_____DOB_____

Secondary insurance_____Policy#_____
Group#_____Phone#_____SS#_____
Name of insured & Relationship:_____DOB_____

Name of person or persons authorized to receive your medical information:

Name:_____Relationship:_____
Name:_____Relationship:_____

Please read carefully before signing

I certify that the above information is correct. I consent to be treated by the staff and Dr. Rensch. I authorize payment of benefits to Dr. Rensch and authorize them to release any information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services at the TIME OF SERVICES.

Patient/ Guarantor Signature:_____Date_____

420 WATER ST, #103, KERRVILLE, TX 78028 WWW.HILLCOUNTRYDIGESTIVEHEALTH.COM
PHONE 830-257-0375 FAX 830-257-0049 HCDH1@GMAIL.COM

PERSONAL HISTORY

Primary care physician:_____ Phone_____

Reason for your visit:_____

_____

Past/current medical history: (circle any that apply)

Acid Reflux Stomach ulcers Crohn's or colitis IBS Colon cancer Colon polyps

Diverticulitis/losis Hemorrhoids Anal fissure Hepatitis A/B/C Gallstones

Liver problems Pancreatitis Heart attack Diabetes Anemia Bleeding disorder

Cancer:_____ Other:_____

Current Symptoms: Please circle any that apply

Difficulty swallowing Heartburn/GERD Nausea Vomiting Indigestion Bloating

Abdominal pain Belching/Gaseousness Gastrointestinal bleeding Constipation

Diarrhea Hemorrhoids Change in bowel habits Weight loss Weight gain Fatigue

Weakness Loss of appetite Blood in stool Black stool White stool Anal/rectal pain

Fecal incontinence/soiling Jaundice Sore throat Mouth sores/ulcers

Other:_____

Past surgical history: (circle any that apply)

Colon resection Small bowel surgery/resection Appendectomy Gallbladder

Hemorrhoidectomy Gastric bypass Pacemaker Hysterectomy Tonsillectomy

Other:_____

Social History:

Alcohol: Daily Occasionally Former Never
Tobacco: Current Former Never
Drugs: Current Former Never

Family Medical History:

Colon cancer Colon polyps Crohns/Colitis Liver disease Diabetes Stomach cancer
Prostate cancer Ovarian cancer Breast cancer Uterine Cancer
Other:_____