Hello and welcome to Dr. Liz Cruz Partners in Digestive Health. As the owner and founder of this practice, I just wanted to say thank you for coming in today and trusting my team and I with your journey to digestive health! We've been serving patients since 2007 and I'm constantly reflecting about the mission we have here at our practice. I feel so passionately about it that I want to share it with you.

At Dr. Liz Cruz Partners in Digestive Health we are in the business of partnering with our patients to deliver world-class traditional GI medical evaluations combined with a proven holistic approach that eliminates fear and accelerates life-long health and wellness.

If you feel this is for you, welcome! We wouldn't be here without you and you are what make this journey special to all of us! We are going to work hard with you to provide the best experience we know how. For those of you that are new to our practice below is a brief explanation of what's in store for you. For those of you that have been with us for a while we want to inform you of some changes we are making to improve your experience in working with us.

Everything you come in for will start with an in-office visit with one of our highly trained and experienced Nurse Practitioners. They will see you in consult and determine what tests and procedures need to be run to assist you on your journey to digestive health. Some of the tests and procedures will be traditional and some will be more holistic. We want you to know that we are offering you the best of the best to get to the bottom of your symptoms as soon as possible.

When you check out from your in-office appointment, tests and procedures will be scheduled or ordered and you will also be asked to schedule a follow-up appointment here in the office to review all of your results. **WE WILL NO LONGER BE CALLING OR MAILING RESULTS. WE FIND THAT HAVING A FACE-TO-FACE APPOINTMENT TO REVIEW RESULTS AND NEXT STEPS LEADS TO BETTER OUTCOMES.**

All GI procedures will be performed by myself or one of my partners. Once all your results from all tests and procedures are received, we will discuss them with you during your follow-up appointment. At that time we will offer you a traditional approach to healing along with a more holistic approach. It is up to you to decide what you'd like to pursue. Please know we will never push anything on you, we just want to make sure you have all options available to you.

We have also implemented many new communication tools to better serve you. We are incorporating automated voice and text messages for appointment reminders, along with using the patient portal for more efficient communication. Once you are registered with the practice, you will receive a login id and password sent to your email so you can access the portal. **IF YOU ARE A LONG TIME PATIENT OF OURS AND HAVEN'T TAKEN ADVANTAGE OF THIS COMMUNCIATION TOOL, WE STRONGLY SUGGEST TALKING WITH OUR RECEPTIONIST AND GETTING THE EMAIL RESENT TO YOU.** By using the portal, you no longer have to call the office, leave a message and wait for a response. We're looking forward to you taking advantage of this amazing tool!

We hope you enjoy the new journey as none of this would be possible without you.

Thank you. Thank you. Thank you.

Liz Cruz MD

Dr. Liz Cruz

_____

Sign Here Acknowledging Receipt

P 623-772-6999 F 623-772-6444 E support@drlizcruz.com

4110 N. 108th Avenue, Ste 105, Phoenix, AZ 85037

drlizcruz.com

Patient Registration

PATIENT INFORMATION - the person being seen by the doctor

Last Name_____First_____Initial_____
Home Address_____Zip_____City_____State_____
Mailing address_____Zip_____City_____State_____
Email_____ I am willing to receive emails from Dr. Liz Cruz? Yes / No
Home Phone_____Cell or Pager_____ Primary Care Physician_____
Patient's Relationship to Policyholder (circle one) Self / Spouse / Child / Other
Date of Birth_____ Patient Sex _____Male _____Female
Patient's Social Security_____ Patient Language Preference:_____
Patient's Race: (circle one) American Indian / Alaska Native / Asian / African American / Native Hawaiian / Hispanic / White / Pacific Islander / Other / Refuse to Report
Patient's Marital Status: (circle one) Married / Single / Widowed / Legally Separated / Divorced / Other
Patient's Employer_____Occupation_____
Address_____Zip_____City_____State_____Phone_____
Preferred Pharmacy Name:_____ Cross Streets/City:_____

GUARANTOR INFORMATION - the person who carries the insurance policy or is responsible for payment

Last Name_____First_____Initial_____
Home Address_____Zip_____City_____State_____
Home Phone_____Cell or Pager_____ Email Address_____
Social Security _____ Date of Birth _____
Mailing address_____Zip_____City_____State_____
Guarantor Employer_____Occupation_____
Address_____Zip_____City_____State_____Phone_____

Primary Insurance _____ID#_____Group#_____
Secondary Insurance _____ID#_____Group#_____
Guarantor for Secondary?_____ Social Security_____
Date of Birth _____ Mobile Phone_____

I authorize release of any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Dr. Liz Cruz Partners in Digestive Health. I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the Insurance carrier. I also understand if I receive a screening colonoscopy some insurances pay differently depending on what is found during the procedure. It is my responsibility to contact my insurance company directly regarding questions pertaining to this. In the event that my account is assigned to a collection agency, I agree to pay an additional collection fee of 25% of the outstanding balance assigned to the collection agency. I also agree to pay any interest on the principal balance, court cost and attorney fees associated with the collection of my account. **In addition, I am aware that if I cannot attend a scheduled appointment I must call at least 24 hours in advance to avoid a $20 no show fee. If I cannot attend a scheduled procedure, I must call at least 5 business days in advance to avoid a $250 cancellation / rescheduling fee.**

_____ _____ _____
Patient Signature Date Staff Initials

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Contact Information

I may be contacted in the following manner (circle all that apply):

-OK to leave message with detailed information: Home Work Cell No
-OK to send mail to: Home Work No
-OK to text my cell: Cell Number:_____ No

Those who may receive information regarding me:

The first person on this list will be your emergency contact (please provide a phone number other than your home)
You must have at least one person on this list.

Name_____Relationship_____Phone #_____
Name_____Relationship_____Phone #_____

Do you have an advanced directive for Healthcare (living will or medical Power of Attorney)?
If yes, we are required to have a copy on file._____Copy Received_____Copy Requested

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Acknowledgement of Receipt of Privacy Notice

Original to be maintained in patient's permanent medical record.

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship (legal guardian, personal rep., etc.)

Notification of Outpatient Practice & Practice Policy

I understand that through Dr. Liz Cruz Partners in Digestive Health, Dr. Elizabeth Cruz has established an outpatient practice. I understand that if I were to be hospitalized for any digestive related issue (not including issues relating to procedures performed by Dr. Cruz directly) I will be seen by the physician on call at that particular hospital and not Dr. Cruz.

Out of respect for our providers and the large number of patients we care for on a daily basis we have implemented the following cancellation / rescheduling policy. If you cancel or reschedule a procedure or in-office appointment 3 times in a row you will be discharged from the practice.

In addition, we strive to treat all patients with the utmost care and respect. We request the same respect from our patients. We will not tolerate verbal abuse, profanity or any other form of disrespect to the members of our team. This behavior will be grounds for immediate discharge from the practice.

_____ _____
Patient Signature Date

Emergency Medical Care Notice

If you feel any of your symptoms have worsened at any time after your office visit YOU are responsible for obtaining Emergency Medical Care at the nearest emergency room. If YOU choose not to seek prompt medical care for your symptoms, please be advised we are not responsible for the outcome. I have read and understood the information on emergency services provided above and agree to seek emergency medical care if my symptoms worsen. If I choose not to seek prompt medical care, I will not hold my provider responsible in any capacity for the outcome.

_____ _____
Patient Signature Date

Patient Intake Form

Name:_____ Age:_____ Date of Birth:_____ Date: _____

Height: _____Weight: _____ Who is your primary doctor? _____ Referring Physician?_____

Reason for seeing a Gastroenterologist:_____

Have you had a ____ Colonoscopy or ____ Sigmoidoscopy done in the past 10 years? Yes No
If yes, what year was it performed?_____ Anything found?_____

Have you had an Upper Endoscopy done in the past 10 years? Yes No
If yes, what year was it performed?_____ Anything found?_____

Has anyone in your immediate family been diagnosed with colon cancer or polyps? Yes No
If yes, please explain:_____

Have you ever seen a cardiologist? Yes No If yes, who?_____ How often?_____

Have you ever seen a pulmonologist? Yes No If yes, who?_____ How often?_____

Medications:

Do you take pain / arthritis medication such as **ASPIRIN OR NSAIDS** (Ibuprofen, Naproxen, Aleve, Motrin, Advil)? Yes No
If yes, please name medication & frequency:_____

Do you take **BLOOD THINNERS** (Eliquis, Xarelto, Pradaxa, Brilinta, Coumadin, Warfarin, Heparin, Lovenox, Plavix)? Yes No
If yes, please name medication & frequency:_____

Please list other medications you are taking (include "over-the-counter" medicine and doses if possible)

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Preferred Lab: (please circle one) Sonora Quest Lab Corp. Other_____

Allergies to Medicine:
Are you allergic to any medication? Yes No
If yes, please name medications & reactions:_____
_____

Date of Last Flu Vaccine:_____

CURRENT SYMPTOMS: (check all that apply)

___Abdominal pain
___Nausea
___Vomiting
___Bloody vomiting
___Fevers
___Chills
___Loss of appetite
___Weight loss
___Change in bowel habits
___Diarrhea
___Constipation
___Rectal bleeding
___Blood in stool
___Blood on toilet paper
___Hemorrhoids
___Anal pain
___Black, tarry stool
___Gas / bloating
___Heartburn
___Acid reflux
___Belching/Burping
___Indigestion
___Lactose intolerance
___Difficulty swallowing
___Food sticking in esophagus
___Painful swallowing
___Jaundice
___Abnormal liver tests
___Anemia
___Stool incontinence

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PAST MEDICAL/SURGICAL HISTORY (check all that apply)

___None
___High Blood Pressure
___Heart Attack/MI
___Heart Disease/Stents
___Elevated Cholesterol
___Heart Valve Problem/Murmur
___Congestive Heart Failure
___Atrial Fibrillation
___Heart Arrhythmia
___Blood Transfusions
___Pacemaker/Defibrillator
___Asthma
___Lupus
___History of Colon Polyps
___Removal of tonsils
___Removal of gallbladder
___Removal of appendix
___Hiatal hernia repair
___Removal of uterus
___Removal of ovary/ovaries
___Cancer, type(s):_____

___Emphysema/COPD
___Valley Fever
___Tuberculosis
___Sleep Apnea
___Lung Clots
___Diabetes Mellitus
___Seizure Disorder
___Stroke/TIA
___Alzheimer's Disease
___Parkinson's Disease
___Thyroid Disease
___Bleeding Disorder
___Kidney problems
___Tubaligation
___C-section
___Prostate surgery
___Thyroid surgery
___Lung surgery
___Gastric bypass surgery
___Colon surgery

___Hemophilia
___GERD/Acid Reflux
___Barrett's Esophagus
___Hiatal Hernia
___Stomach / Duodenal Ulcer
___Celiac Disease
___Helicobacter Pylori
___Irritable Bowel (IBS)
___Crohn's Disease
___Ulcerative Colitis
___Pancreatitis
___Hepatitis
___Hemodialysis
___Stomach ulcer surgery
___Hemorrhoidectomy
___Inguinal hernia repair
___Abdominal hernia repair
___Total knee replacement
___Total hip replacement
___Bladder suspension

___Fatty liver
___Diverticulosis
___Diverticulitis
___Anemia
___Depression
___Anxiety Disorder
___Bipolar Disorder
___Schizophrenia
___Arthritis
___Osteoporosis
___Fibromyalgia
___HIV/AIDS
___Liver Cirrhosis
___Rectal prolapse surgery
___Coronary bypass
___Heart valve replacement
___Pacemaker placement
___Defibrillator (AICD)

PLEASE LIST OTHER MEDICAL/SURGICAL HISTORY THAT MAY HAVE NOT BEEN LISTED:

_____

_____

Social History/Marital Status:

___Single ___Married ___Divorced ___Separated ___Widowed

Your occupation: _____ Retired_____ Unemployed_____ Disabled_____

Do you / have you ever used tobacco? ____Yes ___No Packs per day?_____ Years?_____ Date Quit?_____

Do you use alcohol? ____Yes ___No ___Beer ___Wine ___Liquor How often?_____ How much?_____

Have you ever used street drugs? ____Yes ____No Type_____ Last use_____

FAMILY HISTORY

Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

_____Colon polyps
_____Colon cancer
_____Rectal cancer
_____Uterine / Cervical cancer

_____Stomach cancer
_____Small bowel cancer
_____Esophageal cancer
_____Skin cancer (ie. Melanoma)

_____Liver cancer
_____Pancreatic cancer
_____Crohn's Disease
_____Other Cancer (please describe)

_____Ulcerative Colitis
_____Celiac Disease
_____Gallbladder Disease

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ Date:_____

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