Marc L. Kozam, MD
Gastroenterology & Hepatology
Diagnostic & Therapeutic Endoscopy
Board Certified

18111 Prince Philip Drive, Suite T-14
Olney, MD 20832-1513
Voice: 301-774-4400 (24hr)
Facsimile: 301-774-1034
Email: Office@drkozam.com

Please take a few minutes to provide information that will allow us to provide excellent care. The first 15 minutes of your appointment have been reserved for this task.

PATIENT INFORMATION

Date: _____ Soc. Sec (opt): _____ Birthday: _____

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: _____ Message OK: ☐Text OK? ☐

Alternate phone #1: _____ Message OK: ☐Text OK? ☐

Alternate phone #2: _____ Message OK: ☐Text OK? ☐

Email: _____

Sex: ○M ○F Marital Status: ☐Single ☐Married/Partner ☐Separated ☐Divorced ☐Widowed

Employer: _____ Work Phone: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____

Referring Physician (if different): _____

Pharmacy: _____

Medical reason for visit: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Marc L. Kozam for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I may also, to the extent permitted by law, be responsible for legal fees associated with collection of any unpaid debt.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

I have received a copy of the practice privacy notice, that I may keep for my records, detailing how my medical information will be used and protected.

Signature of Responsible Party: _____ Date: _____

PLEASE PROCEED TO MEDICAL HISTORY ON THE NEXT PAGE

ALLERGIES/SENSITIVITIES TO MEDICATIONS

Drug/Nature of reaction or sensitivity

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS AND DOSE/FREQUENCY (Include over the counter and herbal)

_____ _____ _____

_____ _____ _____

_____ _____ _____

MAJOR MEDICAL CONDITIONS/HOSPITALIZATIONS/SURGERIES

Date of Onset Nature of Problem & Outcome

_____ _____

_____ _____

_____ _____

_____ _____

HEALTH HABITS

Caffeine: _____ Alcohol: _____ IV Drugs: _____

Tobacco: _____ Cocaine: _____ Exercise: _____

FAMILY HISTORY

Relationship Health Problems/Cause of Death

Mother _____

Father _____

Siblings _____

Children _____

REVIEW OF SYSTEMS

Checkmark current symptoms and major health problems in the past.

General
- ☐ Cancer
- ☐ Unexplained fever
- ☐ Unexplained weight loss

Cardiovascular
- ☐ Arrythmia
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Valve Disease

Endocrine
- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Excessive Gas
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hepatitis/Jaundice
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Nausea
- ☐ Polyps
- ☐ Reflux
- ☐ Rectal Bleeding
- ☐ Swallowing difficulty
- ☐ Ulcer
- ☐ Vomiting

Hematological
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Enlarged lymph nodes

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Replacement

Neurological
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Stroke/TIA

Ophthalmic
- ☐ Glaucoma
- ☐ Cataracts

Psychiatric
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia

Pulmonary
- ☐ Asthma
- ☐ Persistent Cough
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

Reproductive
- ☐ Abnormal menses
- ☐ Urinary tract infection
- ☐ Painful Urination

Thank you for providing this information. It will help make your visit more thorough and will improve your care.