First State
GASTROENTEROLOGY

Date: _____ Name: _____ Dr. Who Referred You: _____

Age: _____ Height: _____ Reason for Visit: _____

PAST MEDICAL HISTORY (Please Circle if Applicable)

Colon Cancer	High Blood Pressure	Lupus	Emphysema/COPD
Colon Polyps	Heart Disease	Atrial Fib	Sleep Apnea
Crohn's Disease	Heart Failure/Heart Attack	Stroke/TIA	Diabetes
Ulcerative Colitis	High Cholesterol	Pancreatitis	Heart Murmur
Irritable Bowel (IBS)	Pacemaker	Asthma	Kidney Disease/Dialysis
Heartburn/Reflux	Defibrillator	Thyroid Disorder	Rheumatoid Arthritis
Anxiety	Depression		

PAST SURGICAL HISTORY (Please Circle if Applicable)

Colon	Gastric Bypass	Gallbladder	Appendix	C-Section
Hysterectomy	Heart Bypass			

Any Other Surgeries: _____

MEDICATIONS: (If you have a list of medications please let us know, we can make a copy of it)

_____

_____

_____

MEDICATION ALLERGIES: _____

FAMILY HISTORY (Please Circle if Applicable)

Colon Cancer	Colon Polyps	Stomach Cancer	Ovarian Cancer
Endometrial Cancer	Pancreas Cancer	Kidney Cancer	Esophagus Cancer
Gallbladder Cancer	Crohn's Disease	Ulcerative Colitis	Liver Disease

PERSONAL HISTORY

Occupation _____ Amount of alcohol use each week _____

Please circle one: Current/Previous Tobacco user Tobacco use per day _____

Tattoos (YES/NO) Blood Transfusion prior to 1992 (YES/NO)

Date of Last Colonoscopy: _____

SYSTEMS REVIEW (Please Circle if Applicable)

Snoring	Chest Pain	Palpitations	Shortness of Breath
Chronic Cough	Headaches	Ear Ringing	Numbness
Tingling	Blurry Vision	Sore Throat	Blood in Urine
Difficulty Urinating	Depression	Fatigue	Joint Pain
Muscle Pain	Easy Bruising	Easy Bleeding	Chills
Sweats	Fever	Rash	

PATIENT BILLING INFORMATION

TODAY'S DATE: _____ DATE OF BIRTH: _____ AGE: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____

HOME PHONE #: _____ CELL PHONE #: _____

EMPLOYER NAME: _____ WORK PHONE #: _____

SEX (circle): MALE FEMALE ETHNIC (circle): HISPANIC NON-HISPANIC DECLINED

RACE (circle): WHITE BLACK ASIAN INDIAN PAC ISLAND DECLINED

MARITAL STATUS (circle): SINGLE MARRIED WIDOWED DIVORCED

REFERRED BY DR: _____ FAMILY DOCTOR: _____

PHARMACY NAME: _____ PHARMACY PHONE #: _____

MINOR INFORMATION

IF PATIENT IS A MINOR, GUARDIAN'S NAME: _____

RELATIONSHIP TO PATIENT: _____

EMPLOYER FOR GUARDIAN: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE FIRST STATE GASTROENTEROLOGY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF MY ORIGINAL SIGNATURE FOR BILLING. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU.

SIGNATURE : _____ DATE: _____

(patient, parent, authorized signature)

The information contained herein is for informational purposes only and is provided on an "as is" basis. WVMI, Quality Insights of Delaware, and their employees make no representation concerning the suitability or accuracy of this information for any purpose. Neither WVMI, Quality Insights of Delaware, nor any of their employees makes any warranty, express or implied, including warranties of merchantability and fitness for a particular purpose, or assumes any legal liability or responsibility for the accuracy, completness, or usefulness of any information, apparatus, product or process disclosed, or represents that its use would not infringe privately owned rights and shall not be liable for any damages whatsoever arising from the use of or reliance on any information contained herein.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand FSG's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that FSG may update its Notice of Privacy Practices at any time and that I may receive an updated copy of FSG's Notice of Privacy Practices by submitting a request in writing for a current copy of FSG's Notice of Privacy Practices.

X PATIENT NAME (PRINT):_____

X PATIENT SIGNATURE:_____ X DATE:_____

If completed by patient's personal representative, please print andsign below.

PERSONAL REPRESENTATIVE:_____

RELATIONSHIP TO PATIENT:_____

REPRESENTATIVE SIGNATURE:_____ DATE:_____

FOR FIRST STATE GASTROENTEROLOGY ASSOCIATES OFFICIAL USE ONLY

Complete this form if unable to obtain signature of patient or patient's personal representative.

FSG made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

_____ Patient or patient's personal representative refused to sign.

FIRST STATE GASTROENTEROLOGY

DR. ASHISH P. SHAH, M.D.

DR. PARAG J. LODHAVIA, M.D.

644 SOUTH QUEEN STREET, SUITE 106

DOVER, DE 19904

302-678-9002 302-678-9807 (fax)

EMERGENCY CONTACTS

I choose to designate the individuals listed below as my primary contacts. **First State Gastroenterology Association's** personnel may share my information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's Name: _____ DOB: _____

#1 Contact Name: _____
Relationship to Patient: _____
#1 Contact Phone Number: _____

#2 Contact Name: _____
Relationship to Patient: _____
#2 Contact Phone Number: _____

Patient's Signature: _____ Date: _____
(patient, parent, authorized signature)

FIRST STATE GASTROENTEROLOGY

Dr. Asish P. Shah, M.D.

Dr. Parag J. Lodhavia, M.D.

Important Billing and Insurance Information for our Patients

Thank you for selecting our practice for your gastrointestinal health. The following information is very important to receive coverage from your insurance company.

1. Your insurance company often requires a referral and/or a prior authorization from your Primary Care Physician. If your insurance company requires a referral or authorization you WILL NEED this PRIOR to your office visit with us. This is a policy which your insurance company has and we are required by your insurance company to obtain this number prior to seeing you. Anyone without a proper authorization will not be seen.

2. Many insurance policies have co-pays and/or deductibles which must be paid at the time of service. Once again, this is required by your insurance company.

3. Please know your insurance coverage in detail. Even the same insurance company offers several different policies with different coverages. For example, some Blue Cross plans require a referral for each specialist, office visit, and procedure: while other Blue Cross plans do not require a referral. These policies may change every year. So, please call your insurance company, workplace, or review your insurance handbook to have an understanding of your co-payments, deductibles, referral requirements and where to go for special tests, such as x-rays and blood work, to obtain the best coverage.

4. Please understand that our office calls your insurance company to get a prior authorization for a procedure based on your symptoms. However, this is not a guarantee of payment by your insurance company.

5. If your insurance company does not pay for your specialist visit or testing, you are responsible for that payment in a timely manner after reasonable efforts have been made to receive payment from your insurance company.

6. If you do not give 24 hours notice for canceling an appointment or procedure, you will be charged. It is a $25.00 fee for office visits and $75.00 fee for procedures. This charge is your responsibility, not your insurance company.

7. A $45.00 charge for any returned checks. Co-pays and payments are expected at time of service.

I acknowledge reading the above information.

Signature: _____ Date: _____

(patient, parent, authorized signature)