First State
GASTROENTEROLOGY

PATIENT HEALTH HISTORY FORM

Name: _____ Date: _____ Referring Doctor: _____
Age: _____ Height: _____ Weight: _____ Reason for your visit: _____

PAST MEDICAL HISTORY (Please check if applicable):

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

PAST SURGICAL HISTORY (Please check if applicable):

- ☐ Colon
- ☐ Gallbladder
- ☐ Other: _____
- ☐ Appendix
- ☐ C-Section
- ☐ Hysterectomy
- ☐ Heart Bypass
- ☐ Bariatric Surgery

Date of last Colonoscopy: _____

FAMILY HISTORY (Please check if applicable):

- ☐ Colon Cancer (If so, who): _____
- ☐ Colon Polyps (If so, who): _____
- ☐ Endometrial Cancer
- ☐ Pancreas Cancer
- ☐ Stomach Cancer
- ☐ Kidney Cancer
- ☐ Ovarian Cancer
- ☐ Esophagus Cancer
- ☐ Liver Disease
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease

ALLERGIES: _____

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

PERSONAL HISTORY:

Occupation: _____ **Amount of Alcohol use each week:** _____

Please check one: ☐ Current Tobacco User ☐ Previous Tobacco User ☐ Never a Tobacco User

SYSTEMS REVIEW (Please check if applicable):

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

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OFFICE REGISTRATION FORM

Name:	**Date of Birth:**		**Sex (circle):** Male Female
Address:	**City:**	**State:**	**Zip:**
Home Phone #:	**Cell Phone #:**		
Social Security #:	**Race (circle):** White African American Asian Indian Pacific Island Declined		**Ethnicity (circle):** Hispanic Non-Hispanic Declined
Marital Status (circle): Single Married Divorced Widowed	**Email Address:**		
Employer Name:	**Work Phone #:**		

IF PATIENT IS A MINOR

Guardian's Name:	**Relationship to patient:**	**Phone #:**

Referring Doctor: _____ **Primary Care Doctor:** _____
Pharmacy: _____ **Phone #:** _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy ID: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____
Secondary Insurance: _____ Policy ID: _____
Policy Holder's Name: _____ Date of Birth: _____ Relationship: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize First State Gastroenterology to furnish information to insurance carriers concerning my illness and treatments. 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.

PATIENT NAME (PRINT):_____

PATIENT SIGNATURE:_____ 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. PARAG J. LODHAVIA, M.D.

KAYLA BEAUPLAN, P.A.-C

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. 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 48 hours notice for an office visit cancellation you will be charged a $25.00 cancellation fee. If you do not give 48 hours notice for canceling a procedure, you will be charged a $75.00 fee. These charges are 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)