PATIENT DEMOGRAPHICS

FULL NAME: ______________________ DOB: __________

MAILING ADDRESS: ______________________________

CITY: ______________ STATE: ____________ ZIP: ________

HOME PHONE #: ______________ CELL PHONE #: ________________

EMPLOYER NAME: __________________ WORK #: ______________

SOCIAL SECURITY #: ____________ EMAIL: ________________

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

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

MARITAL STATUS (circle): SINGLE MARRIED DIVORCED WIDOWED

REFERRED BY DR: ______________ FAMILY DOCTOR: ______________

PHARMACY NAME: ______________ PHARMACY PHONE #: ____________

PLEASE CIRCLE ONE: IS INSURANCE AN HMO/PPO/EPO PLAN?

TYPE OF INSURANCE: ______________ INS ID #: ________________

POLICY HOLDERS NAME: ________________ DOB: __________

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)

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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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, MD

DR. TEMITAYO GBOLUAJE, MD, MBA

KAYLA BEAUPLAN, PA-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, MD

Dr. Temitayo Gboluaje, MD, MBA

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)