

STONE OAK GASTROENTEROLOGY

19284 Stone Oak #102; SATX 78258 * 3338 Oakwell Ct #205; SATX 78218 * 20540 Hwy 46 #103; Spr Br, TX 78070 * 717 Generations Dr. #B, NB TX 78130
SCHEDULING: (210) 268-0122 or (210) 268-0159 *** OFFICE: (210) 268-0124 *** FAX: (210) 268-0141 *** www.STONEOAKGI.com

Seema A. Dar, MD -- Chaithanya Mallikarjun, MD -- Desh B. Sharma, MD

Welcome To Our Practice

Patient Information

Date _____

Name (Last, First, MI) _____

Date of birth: _____ Soc. Sec: # _____ Gender: M[] F[]

Address _____ City, State, Zip: _____

Referred by _____ Primary Care Physician (PCP) _____

STATE REQUIRED ETHNICITY AND RACE QUESTIONNAIRE

Race _____ Ethnicity _____ Language _____

Telephone Numbers

Mobile (_____) - _____ Home (_____) - _____ Work (_____) - _____

Email Address _____@_____.com

Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed [] Life Partner

Emergency Contact

Name _____ Relationship _____

Primary number (_____) - _____ Secondary number (_____) - _____

Insurance Information

*Primary insurance _____ Policy # _____ Group # _____

Policy holder's name _____ Date of birth _____ SS # _____

*Secondary insurance _____ Policy # _____ Group # _____

Policy holder's name _____ Date of birth _____ SS # _____

Pharmacy Information

Pharmacy _____ Address/Location _____

Telephone number (_____) - _____ Fax number (_____) - _____

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CONSENT OF UNDERSTANDING ON PATIENT RIGHTS AND PRIVACY NOTICE

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purposed of treatment, payment or healthcare operation (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with STONE OAK GASTROENTEROLOGY.”

“It is our policy to provide a substitute health care provider, authorized by STONE OAK GASTROENTEROLOGY to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

I have read the Privacy Notice and understand my rights as a patient contained in the Notice.

By way of my signature, I provide **STONE OAK GASTRONTEROLOGY** with my authorization and consent to use and disclose my protected healthcare information, PHI, for the purposes of treatment, payments, and healthcare operations as described in the Privacy Notice. A copy is available to take upon request.

SIGNATURE OF PATIENT/GUARDIAN

PRINTED NAME

DATE

AUTHORIZED FACILITY SIGNATURE

PRINTED NAME

DATE

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AUTHORIZATION TO RELEASE MEDICAL CARE INFORMATION

(Healthcare Providers or Facility)

Name (Last, First MI) _____

Date of birth: _____ Soc. Sec: # _____ Gender: M[] F[]

Address _____ City, State, Zip: _____

I hereby authorize _____, to release copies of my medical records concerning any
(Name of other Provider/Facility)
Illness, Treatment or recommendations while I was patient of the above listed medical Facility or Physician(s).

I understand that my medical records may contain copies of Information received from another health care facility or physician(s). I also understand that the above information may contain reference results (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party.

Information to be released:

_____ Chart Note _____ Labs _____ X Rays
_____ Procedure _____ Medication _____ ALL RECORDS

FAX TO: **STONE OAK GASTROENTEROLOGY**

Attn: Medical Records
19284 Stone Oak Pkwy #102
San Antonio, TX 78258
Phone: (210) 268-0124
Fax# (210) 268-0141

For the Purpose of: *CONTINUITY OF CARE*

Patient Signature

Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Family and/or Friend)

In accordance with the HIPAA law, it is required that you provide our office with the name of any person to whom you want the release of your personal health records; via over the phone, by fax, or e-mail. This does **NOT** include other healthcare providers you see. This is YOUR FAMILY MEMBER or FRIEND.

I hereby give permission for the following parties mentioned below to obtain information in regards to my medical records at Stone Oak Gastroenterology.

- | | | | |
|----|---------------------------|---------------------|---------------------|
| 1. | _____ | _____ | _____ |
| | NAME OF INDIVIDUAL | RELATIONSHIP | PHONE NUMBER |
| 2. | _____ | _____ | _____ |
| | NAME OF INDIVIDUAL | RELATIONSHIP | PHONE NUMBER |
| 3. | _____ | _____ | _____ |
| | NAME OF INDIVIDUAL | RELATIONSHIP | PHONE NUMBER |
| 4. | _____ | _____ | _____ |
| | NAME OF INDIVIDUAL | RELATIONSHIP | PHONE NUMBER |
| 5. | _____ | _____ | _____ |
| | NAME OF INDIVIDUAL | RELATIONSHIP | PHONE NUMBER |

SIGNATURE OF PATIENT/GUARDIAN

PRINTED NAME

DATE OF SIGNATURE

SIGNATURE OF POWER OF ATTORNEY

PRINTED NAME

DATE OF SIGNATURE

(IF APPLICABLE)

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PROCEDURE CANCELLATION POLICY

When a procedure appointment is scheduled with us, we reserve a block of time especially for you. In that situation, it will include the MD, an anesthesiologist, and multiple RN's, which all charge for time, irrespective of whether you show up or not. If you do not appear for your procedure, that block of time is unavailable to someone else who is waiting for our care.

We require a **2 BUSINESS DAYS** to cancel or reschedule a procedure.

If you fail to give the required notice in the allotted time, you will be subject to a fee that will not be covered by your insurance.

Some examples of cancellation fees are as follows:

OFFICE VISIT	\$50 CANCELLATION FEE
COLONOSCOPY/ENDOSCOPY APPOINTMENT	\$200 CANCELLATION FEE
CAPSULE ENDOSCOPY	\$200 CANCELLATION FEE

*** Please give 2 business-day notice to avoid fee ***

Patients will only be exempt from the cancellation fee on emergency situations **ONLY**, i.e. **case-by-case basis**.

Please sign stating that you have read and understand our Procedure Cancellation Policy.

SIGNATURE OF PATIENT/GUARDIAN

DATE OF SIGNATURE

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NAME: _____

DATE: _____

DATE OF BIRTH: _____

REFERRING MD: _____

REASON FOR TODAY'S VISIT? _____

LIST OF SYMPTOMS						
	WHEN DID IT START? (# of days ago, months, etc.)	HOW OFTEN? (Constant, daily, weekly, monthly, etc.)	TIME OF DAY? (AM/PM or N/A)	RELATED TO DIET? (Describe or N/A)	SEVERITY (1-10 PAIN LEVEL)	ADDITIONAL DESCRIPTION(S)?
Right-Upper Abdomen Pain						Radiates to back? Y / N
Right-Lower Abdomen Pain						
Left-Upper Abdomen Pain						
Left-Lower Abdomen Pain						
Other Abdominal Pain: _____						
Diarrhea						
Constipation						
Fecal leakage						
Hemorrhoids						
Rectal Pain						
Rectal Bleeding						
Black/Tarry Stool						
Nausea						
Vomiting						Bloody Emesis? Y / N
Sour Taste in Mouth						
Excessive Belching						
Heartburn						
Acid Reflux/Regurgitation						
Sore Throat						
Difficulty Swallowing						FOODS SALIVA LIQUIDS PILLS
Sensation something is stuck in throat						
Other: _____						

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FAMILY MEDICAL HISTORY

PLEASE MARK THE APPROPRIATE BOX TO INDICATE WHICH MAY APPLY. IF NONE APPLY, MARK IN THE "HISTORY UNKNOWN/NONE" FIELD.	COLORECTALCANCER	COLORECTAL POLYPS	STOMACH CANCER	CROHN'S DISEASE	ULCERATIVE COLITIS	PANCREATIC CANCER	LIVER CANCER	HEPATITIS	CIRRHOSIS	OVARIAN CANCER	PROSTATE CANCER	BREAST CANCER	UTERINE CANCER	OTHER CANCERS	HEART DISEASE	STROKE	HISTORY UNKNOWN/NONE
MOTHER																	
FATHER																	
SISTER(S)																	
BROTHER(S)																	
MATERNAL G.M.																	
MATERNAL G.F.																	
PATERANAL G.M.																	
PATERANAL G.F.																	

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MEDICAL HISTORY (CONTINUED)

SURGERIES/PROCEDURES	DATE OF SERVICE	HABITS
		<u>SMOKING:</u>
		PACKS DAILY: _____
		# OF YEARS SMOKING: _____
		# OF YEARS AGO, IF STOPPED: _____
		NEVER SMOKED: _____
		<u>CAFFEINE:</u> (SERVINGS PER DAY)
		COFFEE: _____
		SODA: _____
		TEA: _____
		<u>ALCOHOL:</u>
		TYPE: _____
		AMOUNT PER DAY: _____
		AMOUNT PER WEEK: _____
		AMOUNT PER MONTH: _____

RECENT LABS, TESTS, HOSPITALIZATIONS, MD VISITS	DATE/LOCATION	REASON

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MEDICAL HISTORY

ULCERS – STOMACH/DUODENAL YES ___ NO ___
 ACID REFLUX/GERD YES ___ NO ___
 ESOPHAGEAL STRICTURE YES ___ NO ___
 LIVER DISEASE YES ___ NO ___
 ELEVATED LIVER FUNCTION TESTS YES ___ NO ___
 PANCREATITIS YES ___ NO ___
 ALCOHOLISM YES ___ NO ___
 COLON POLYPS YES ___ NO ___
 ANEMIA YES ___ NO ___
 ANGINA YES ___ NO ___
 HEART RHYTHM DISTURBANCE YES ___ NO ___
 HEART PALPITATIONS YES ___ NO ___
 HYPERTENSION YES ___ NO ___
 HYPERLIPIDEMIA YES ___ NO ___
 HEART ATTACK YES ___ NO ___
 CONGENITAL HEART DISEASE YES ___ NO ___
 CONGESTIVE HEART FAILURE YES ___ NO ___
 PACEMAKER/DEFIBRILLATOR YES ___ NO ___
 HEART VALVE REPLACEMENT YES ___ NO ___
 STROKE/TIA'S YES ___ NO ___
 SEIZURES YES ___ NO ___
 DIZZINESS/FAINTING YES ___ NO ___
 ASTHMA YES ___ NO ___
 SLEEP APNEA YES ___ NO ___
 COPD YES ___ NO ___
 DIABETES, TYPE I/II YES ___ NO ___
 KIDNEY DISEASE YES ___ NO ___
 GENITOURINARY DISEASE YES ___ NO ___
 THYROID/ENDOCRINE DISEASE YES ___ NO ___
 PSORIASIS YES ___ NO ___
 AUTOIMMUNE DISEASE YES ___ NO ___
 ARTHRITIS YES ___ NO ___
 GOUT YES ___ NO ___
 MENSTRUAL PROBLEMS YES ___ NO ___
 GYNOLOGICAL PROBLEMS YES ___ NO ___
 CANCER: _____ YES ___ NO ___
 OTHER: _____ YES ___ NO ___

Pharmacy Information

Pharmacy _____
 Address or Location _____
 Phone #: _____
 Fax #: _____

REVIEW OF SYMPTOMS

ARE YOU PREGNANT? (IF APPLICABLE) YES ___ NO ___
 DO YOU HAVE A FEVER? YES ___ NO ___
 EXCESSIVE FATIGUE? YES ___ NO ___
 UNINTENTIONAL WEIGHT LOSS? YES ___ NO ___
 LOSS OF APPETITE? YES ___ NO ___
 DEPRESSION? YES ___ NO ___
 ANXIETY? YES ___ NO ___
 TENDER LYMPH NODES? YES ___ NO ___
 SWOLLEN LYMPH NODES? YES ___ NO ___
 RECENT/RECURRENT INFECTION? YES ___ NO ___
 RASH? YES ___ NO ___
 SHORTNESS OF BREATH? YES ___ NO ___
 CHEST PAIN? YES ___ NO ___
 PRODUCTIVE COUGH? YES ___ NO ___
 SEASONAL ALLERGIES? YES ___ NO ___

MEDICATION	DOSE	FREQUENCY
DRUG/FOOD ALLERGIES	REACTION	
LATEX ALLERGY?	YES / NO	