Patient Information Sheet

WELCOME TO OUR PRACTICE!

Please help us serve you better by taking a few minutes to provide the following information

PATIENT INFORMATION

TITLE	LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS (ROAD OR STREET)	(APARTMENT # OR SECOND ADDRESS LINE)

ZIP CODE	CITY	STATE

HOME PHONE	SOCIAL SECURITY NUMBER	CELL NUMBER

BIRTHDAY	SEX (M,F)	RACE	EMERGENCY CONTACT PERSON/NUMBER

MARITAL	EMPLOYMENT	STUDENT	REL. TO INSURED
❑ M-MARRIED ❑ W-WIDOWED ❑ S-SINGLE ❑ D-DIVORCED ❑ X-SEPARATED	❑ R-RETIRED ❑ F-FULL ❑ P-PART ❑ N-NONE	❑ P-PART ❑ F-FULL ❑ NONE	❑ OT-OTHER ❑ SE-SELF ❑ SP-SPOUSE ❑ CH-CHILD

EMPLOYER/SCHOOL NAME	EMAIL

STREET ADDRESS (ROAD OR STREET)	(APARTMENT # OR SECOND ADDRESS LINE)

ZIP CODE	CITY	STATE	BUSINESS PHONE

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

TITLE	LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS (ROAD OR STREET)	(APARTMENT # OR SECOND ADDRESS LINE)

ZIP CODE	CITY	STATE

HOME PHONE	SOCIAL SECURITY NUMBER	PATIENT DATA (OFFICE USE ONLY)

BIRTHDAY	SEX (M,F)	RACE	PRIMARY DOCTOR (OFFICE USE ONLY)

MARITAL STATUS	EMPLOYMENT	STUDENT	REL. TO INSURED
❑ M-MARRIED ❑ W-WIDOWED ❑ S-SINGLE ❑ D-DIVORCED ❑ X-SEPARATED	❑ R-RETIRED ❑ F-FULL ❑ P-PART ❑ N-NONE	❑ P-PART ❑ F-FULL ❑ NONE	❑ OT-OTHER ❑ SE-SELF ❑ SP-SPOUSE ❑ CH-CHILD

EMPLOYER/SCHOOL NAME	EMPLOYER CODE (OFFICE USE ONLY)

STREET ADDRESS (ROAD OR STREET)	(APARTMENT # OR SECOND ADDRESS LINE)

ZIP CODE	CITY	STATE	BUSINESS PHONE

ACCOUNT DATA #1	ACCOUNT DATE #2	BILLING CYCLE	LOCATION	ACCOUNT CONTROL

PRIMARY INSURANCE COMPANY NAME	MAILING ADDRESS	POLICY #

SECONDARY INSURANCE COMPANY NAME	MAILING ADDRESS	POLICY #

I authorize the release of any medical or other information necessary to process insurance claims.

Signed ______________________ Date __________

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed ______________________ Date __________

Gastroenterology Associates of Orangeburg, P.A.
DIGESTIVE ENDOSCOPY CENTER

SECTION 1. *Consent to disclose health information for treatment, payment for services or Healthcare operations*

I understand that my medical record contains both my medical and personal information, details I have discussed with the physician, test results, care planning, communication with other doctors and organizations as a part of management of my medical problems. For those who need to have this information by law or because they are involved in my care or payment for services, I allow unrestricted access.

☐ **I agree with the above**

☐ **I allow access to the medical record, but with the following restriction(s):**

____

____

SECTION 2. *Designation of people or Institution(s) allowed access to your record*

This section allows you to tell our practice, who should be allowed to see your medical record. You are allowed to make changes to these designations any time. Just request us to help you with a new form.

Name of person or Organization allowed to see your information	Comments

I want to allow people or organizations mentioned above to have complete access to my personal medical records/ to portions of the medical record described in the "Comments" section above. **I understand, if the names of people or organizations are not on the list above, they will NOT receive any information from my medical record.**

SECTION 3. *Acknowledgement of receipt of privacy policy of the practice*

I acknowledge I have been given an opportunity to review my rights and responsibilities, the privacy policies of Gastroenterology Associates of Orangeburg/Dig. Endoscopy Center. I understand I may obtain a copy of these upon formal request or view them on the website: http://www.drmurali.com

____

I have reviewed and understood ALL the three sections above.

→ ________________________________ ________________________________

Signature of patient or Legal Guardian Date

PRINT NAME: ______________________ CHART #

N. Murali, MD, FACP, FACG

1131 Cook Road
Orangeburg, SC 29118 USA
Ph: (803) 539-2005/Fax: (803) 539-2314
www.drmurali.com

GASTROENTEROLOGY ASSOCIATES OF ORANGEBURG, PA
N. MURALI, M.D., FACP, FACG
CHAD A. THOMAS, PA-C
1131 Cook Road — Orangeburg, SC 29118-8204
Telephone: (803) 539-2005 Fax: (803) 539-2314
E-Mail: nsmurali@hotmail.com

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature _______________________ Date ___________

GASTROENTEROLOGY ASSOCIATES OF ORANGEBURG- Digestive Endoscopy Center
N.Murali, MD, FACP, FACG / Chad A Thomas, PA-C
1131 Cook Road, Orangeburg, SC 29118. USA.
www.drmurali.com

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1) a basis for planning my care and treatment
2) a means of communication among the many health professionals who contribute to my care
3) a source of information for applying my diagnosis and surgical information to my bill
4) a means by which a third-party payer can verify that services billed were actually provided
5) a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information.

____
____
____

____________________	____________________
Signature of Patient or Legal Representative	**Witness**
Date	**Notice Effective Date or Version**

☐ Accepted ☐Denied

____________	____________	____________
Signature	**Title**	**Date**

Gastroenterology Associates of Orangeburg-Digestive Endoscopy Center

COMPREHENSIVE HEALTH HISTORY

CHART # ______ Phone: ____________________

Patient Name ____________________ E.mail ____________________ Date ____________________

Age ______ Birthdate ____________ Date of last physical examination ____________ Referring Doctor ____________________

What is your reason for visit?

SYMPTOMS Check (X) symptoms you currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear,
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other ____________

Date of last menstrual period ____________

Date of last Pap Smear ____________

Have you had a mammogram? ____________

Are you pregnant? ____________

Number of children ____________

CHRONIC CONDITIONS Check (X) conditions you have had > 1 year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications with dose you are currently taking

____

____

____

____

____

Pharmacy Name ____________________ Phone ____________________

ALLERGIES To medications or substances

____

____

____

____

____

PLEASE COMPLETE PAGE 2 AS WELL

FAMILY HISTORY

Fill in health information about your family, including uncles, aunts and cousins on bothsides of family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (X) if, your blood relatives had any of the following,

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Drug addiction	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Mental illness	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

		Complications If any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes please give approximate dates ______________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS: Please explain which substances you use and describe how much you use

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Does your occupation expose you to any of the following

	Stress
	Hazardous Substances
	. Heavy Lifting
	Other

Your occupation: ______________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever has a change in health .

______________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________________ Relationship to Patient

______________________ Reviewed By

______________________ Date

.
Use the large yellow boxes to add additional details pertaining to your history (just click and type- the program will auto-format)

Please write down the questions you want to ask the doctor at each visit. Click in one of the yellow boxes and start typing

Gastroenterology Associates of Orangeburg, MEDICATION RECORD

Chart #: ______ Mr ☐ Ms ☐ Mrs. ☐ ______________________________ Age-______

Ref by: ________________ Phone #:____________ E-mail:________________ Ins: __________

Allergies-__________________________________ Diabetes ☐ HTN ☐ Coumadin ☐ Plavix ☐

PHARMACY: ____

Medications	Date of Service							
BP								
Pulse								
Temp								
Weight								
BMI								
Labs								
X-ray								
Procedure*								