ANESTHESIA/HEALTH QUESTIONAIRE

HAVE YOU HAD OR DO YOU CURRENTLY HAVE: (CHECK YES OR NO)

	YES	NO		YES	NO
Problems with Anesthesia			Tuberculosis		
High Fevers after Anesthesia			Bronchitis, Asthma, Emphysema		
Loose Teeth/Dentures			Any problems with sleep apnea		
Glasses/Contact Lenses			Oxygen Dependent?		
Aneurysms			If yes, How much? _____		
Seizures			Day & Night ___ At night ONLY ____		
Black Outs (Syncope)			Hiatal Hernia/ Nausea/ Heartburn		
Stroke			Hepatitis/ Jaundice		
High Blood Pressure (even if controlled)			Diabetes		
Heart Problems:			Thyroid Trouble		
Heart Attack			Blood Clotting Problems		
Chest Pain			History of Bleeding/ Anemia		
Irregular Heartbeat/Palpitations			Sickle Cell Disease		
Heart Failure			Any Neck or Back problems		
Heart Surgery			Are you pregnant now?		
Heart Valve Problems			Kidney Trouble		
Heart Stents If yes, Date: _____			Are you on dialysis		
Pacemaker			Autoimmune Disease		
Pacemaker with Defibrillator			Lupus or Rheumatoid Arthritis/ other		
Brand: _____			**Family History of:**		
Echocardiogram in the last 18 months:			Colon Cancer		
Test Completed @: _____			Esophageal Cancer		
Stress test in last 18 months:			Stomach Cancer		
Test Completed @: _____			History of Anxiety/ Depression		
Cardiac Cath in the last 18 months:			History of Alcohol or Drug Abuse		
Test Completed @:_____			Do you drink alcohol?		
			How often? _____		
HEIGHT _____			Do you smoke/ Ever smoked?		
			Last smoked? _____ Year		
WEIGHT _____			How many cigarettes a day? ____		

Have you had a colonoscopy/endoscopy before? What year? _____

Drug/Latex/Tape Allergies: _____

Current Medications: _____

_____

Which Pharmacy do you use: _____

Prior Surgeries (include year): _____

_____

Primary Care Physician/ Family Physician

_____ _____

PRINT Patient Name **Patient Sign** **Date**

Lake Gastroenterology Associates

B. Ramaiah, M.D. S. Baskar, M.D. K.Jessamy, M.D. G.Guerrero, ARNP

1858 Mayo Drive, Tavares, FL 32778 620 S. Lake Street, Suite #5, Leesburg, FL 34748
1307 Cleveland Ave, Suite A, Wildwood, FL 34785

Patient Registration DATE: _____/_____/_____

PATIENT SS# _____ MARITAL STATUS _____ DOB _____/_____/_____

PATIENT NAME _____
LAST FIRST MIDDLE

MAILING ADDRESS_____
STREET CITY STATE ZIP

EMAIL ADDRESS _____

PHONE NUMBER _____/_____/_____
HOME CELL WORK

GENDER _____ PRIMARY CARE DR _____ REFERRING DR _____

EMPLOYER/RETIRED/SCHOOL _____ FULL OR PART _____

EMERGENCY CONTACT _____PHONE _____ RELATIONSHIP _____

Name of Laboratory you use _____ Name of Imaging Center you use _____

PRIMARY INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST)

INSURED PARTY'S NAME _____ DOB _____

PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____
STREET CITY STATE ZIP

INSURANCE PLAN/PROGRAM NAME _____ I.D. # _____

SECONDARY INSURANCE INFORMATION

INSURED PARTY'S NAME _____ DOB _____

PHONE NUMBER _____ SOCIAL SECURITY NUMBER _____

INSURANCE PLAN/PROGRAM NAME _____ I.D. # _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Lake Gastroenterology Associates LLC for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PLEASE INITIAL _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Lake Gastroenterology Associates, LLC, to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

PLEASE INITIAL _____

LIFETIME AUTHORIZATION FOR MEDICARE/MEDIGAP

PATIENT NAME _____ MEDICARE/MEDIGAP # _____

I hereby give consent to Lake Gastroenterology Associates, LLC to provide whatever treatment the assigned physician may deem necessary to the patient named above.

I understand I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Lake Gastroenterology Associates, LLC for professional physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

I hereby request payment authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Lake Gastroenterology Associates, LLC for any services furnished for me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer of agency shown. In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I request that any payment of authorized MEDIGAP benefits be made on my behalf to Lake Gastroenterology Associates for any services furnished me by Lake Gastroenterology Associates, LLC. I authorize any holder of medical information about me to release to Lake Gastroenterology Associates, LLC any information needed to determine these benefits or the benefits payable for related services.

PATIENT NAME (PRINT) _____

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN (PLEASE PRINT) _____SIGNATURE _____

Lake Gastroenterology Associates

S. Baskar, M.D. G.Guerrero, ARNP
B. Ramaiah, M.D. K.Jessamy, M.D.

1858 Mayo Drive, Tavares, FL 32778
620 S Lake Street, Suite #5, Leesburg, FL 34748
1307 Cleveland Ave, Suite A, Wildwood, FL 34785

Phone: 352-383-5200 **Fax: 352-383-3534**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, give permission for Lake Gastroenterology Associates to release and obtain my medical records from the provider listed _____. I understand that this consent can be cancelled at any time with written notice. A written cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. This authorization will remain in effect as long as I am a current patient and Dr. Baskar/ Dr. Ramaiah/ Dr. Jessamy are participating in my care.

_____

Date of Birth Social Security Number

_____

Patient's Signature

_____

Date

Lake Gastroenterology Associates

S. Baskar, M.D. G.Guerrero, ARNP

B. Ramaiah, M.D. K. Jessamy, MD

Acknowledgement Form

Our notice of Privacy Practice provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, you may obtain a revised copy by writing our practice or requesting a copy from the front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about your treatment, payment and health care operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name:

(**Print**) _____

Signature:

_____

Date:

_____

Witness:

_____

****Please include the name of any friend or relative we may release your information to:**

_____

Patient gives consent for telemed visit if needed

_____

PELVIC EXAMINATION CONSENT FORM

Patient Name: _____

Date of Birth: _____

- **CONSENT:** I, the above listed patient or as the legally authorized person for the patient, hereby, consent to receiving pelvic examinations, i.e. rectal exam, being performed by my physician.

- **NATURE OF PELVIC EXAMINATIONS:**
  For the purposes of this consent form, a "pelvic examination" on a female means the series of tasks that comprise and examination of the rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

  For purposes of the consent form, a "pelvic examination" on a male means examination of the rectum, prostate, and external tissue or organs, this may include, but need not be limited to, the health care provider's gloved hand or instrumentation.

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Patient's Signature Date Time

_____ _____
Legally Authorized Person Signature Relationship to Patient

_____ _____
Legally Authorized Person Printed Name Date Time

_____ _____
Witness Signature Date Time