Lake Gastroenterology Associates

B. Ramaiah, M.D. S. Baskar, M.D.

1858 Mayo Drive, Tavares, FL 32778
1400 US 441,Suite906, The Villages, FL 32159

620 S. Lake Street, Suite #5, Leesburg, FL 34748
910 Old Camp Road, Suite 152, The Villages, FL 32162

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. # ______________________________

Anesthesia/Health Questionaire

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

	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 If YES, how much? ___________________ ☐ Day & Night ☐ At night ONLY		
Aneurysms					
Seizures					
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 problem		
Heart Surgery			Are you pregnant now?		
Heart Valve Problems			Kidney Trouble		
Heart Stents? If yes, Date:			Are you on Dialysis?		
Do you have a Pacemaker			Autoimmune Disesase: Lupus / Rheumatoid Arthritis / other		
Pacemaker with Defibrillator Brand:			**Family History of:** Colon Cancer		
Cardiac Cath in the last 18 months: Test completed @:			**Family History of:** Esophageal Cancer		
			Family History of: Stomach Cancer		
Echocardiogram in last 18 months: (ultrasound x-ray of the heart) Test completed @:			History of alcohol or drug abuse		
			History of Anxiety / Depression		
			Do you drink alcohol? How Often? How Often?		
Stress test in last 18 months: Test completed @:			Do you smoke / Ever smoked? Last smoked? _____________ Year How many cigarettes a day?		
Height: _______________ Weight: _______________					

Have you had a colonoscopy/endoscopy before? If yes, what year? ____________________

Drug/Latex/Tape Allergies: ____________________

Current Medicines: ____________________

____

____

Prior Surgeries (include year): ____________________

____

____

Primary Care Physician/Family Physician:

____

PRINT Patient Name **Date of Birth**

____

Patient Signature **Date**

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 ________________________

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910 Old Camp Road, The Villages, FL 32762
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 are participating in my care.

____

Date of Birth Social Security Number

____

Patient's Signature

____

Date

Lake Gastroenterology Associates

S. Baskar, M.D.
B. Ramaiah, M.D.

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:

____