REGISTRATION FORM - (PLEASE PRINT)

ate:	**PCP's** last name:	First:	Middle:	PCP Ph:

PATIENT INFORMATION

atient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid

s this your legal name?] Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

ace:	Ethnicity:	Religion Preference:
mail:		Language:
treet address:		Social Security:
pt # O. Box:	City:	State: ZIP Code:

Interpreter Needed: ❑ Yes ❑ No

Home ph: ( )

Cell ph: ( )

Work ph: ( )

To which # do you wish to receive appointment reminders?

mployment Status: ❑ Full Time ❑ Part Time]Unemployed ❑ Student ❑ Other:	Employer:	Employer ph: ( )

harmacy's Name Pharmacy's Ph: ( )

low did you hear about us:

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

erson responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )

ccupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

ame of primary insurance:

ubscriber's name:

ubscriber's S.S.:

irth date:

roup:

olicy#:

o payment: $

atient's relationship to subscriber:
] Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :

Subscriber's name:

Subscriber's S.S.:

Birth date:

Group:

Policy #:

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

ame of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

he above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am nancially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge eceipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian Signature *Date*

Maninder S. Guram MD
Texas Gastroenterology Associates
506 Graham Dr. Suite 230
Tomball, TX 77375-3348
(281)205-7522

CANCELLATION & NO–SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. In order to provide all of our patients with the highest level of care and access we request that all patients that need to cancel their appointment provide 24-hours notice. This will enable us to better utilize available appointments for our patients.

Appointments cancelling with less than 24-hours notice or if the patient No-Shows without notification will be subject to a cancellation fee. The cancellation fees are provided below based on the type of appointment:

Office visits	$50.00
In-Office Procedures	$100.00
Hospital Procedures	$250.00

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patients next scheduled appointment.

MEDICATION REFILL'S

If you need a refill on medication please first contact your pharmacy. Please call one week prior to needing your refill

as we need **24 – 48** business hours to refill any medications. If a prior authorization is required you will be required to contact your insurance company.

Patient Name (Please Print)	Date of Birth
Patient Signature or Patient Representative	Date

Authorization and Assignments

Thank you for choosing CHI St. Luke's East Texas Clinical Services. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact or office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

Office Policy

Our providers participate with many health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check In

Please be prepared to submit the following documents when checking in for each visit. These documents will be scanned and saved as part of your patient record.

- Current Insurance Card
- Current Photo Identification
- Update to contact information such as home address, phone numbers, contact information, email address, employer information, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received.

Payment of Patient Responsibility

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

Additional Services Identified During Treatment

Please be aware additional charges may be incurred if during the course of a physical exam a physician addresses, diagnoses, or treats problem-focused health concerns unknown at time of check in.

Non Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic", or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. This clinic will provide medically necessary care based on patient's needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plant's specific benefit and coverage limitations.

Third Parties Insurance

We do not file insurance claims to non-contracted third parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the Time of Service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Appointment Scheduling

Please be advised, as a courtesy, an automated service will call the primary phone number listed on file to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office within 24 hours may result in a $25.00 assessment to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice may result in your dismissal as a patient.

Forms/Medical Letters

We are happy to assist you by completing forms and generating medial letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents. Please allow 10 business days.

Medical Records

Requests for your medical records must be in writing via a special release form. Release of records is managed via an outside vendor. The cost is $25.00 for the 1st 20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is available by telephone 8:00am to 5:00pm Monday through Friday. Because our providers and nurses are often tending to patients, it is typically necessary for you to leave a message. So we may assist you in a timely manner, please leave pertinent information to include the reason for your call and best number to call. We have an answering service to take your calls before and after our scheduled office hours.

- Emergency Needs – always call 911
- Prescription Refills – call during regular office hours and if leaving a message, provide your name, the medication, your pharmacy name, location, and phone number. Refills of controlled substances and/or narcotics MUST be filled by speaking with a medical staff member.

Authorization to Release Information

I hereby authorize CHI St. Luke's Health Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of an examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to CHI St. Luke's Health Medical Group for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I acknowledge I have requested medical services from CHI St. Luke's Health Medical Group, on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I agree to pay CHI St. Luke's Health Medical Group for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services or products administered that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

My signature certifies I have read and understand the above content of this document.

Print Patient Name	Patient Date of Birth
Patient/Guardian Signature	Date

Patient HIPPA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.

The patient reserves the right to change the Notice of Privacy Policies.

The patient may revoke this consent in writing at any time and future disclosures will then cease.

I authorize that your office contact me at (_____) _____ home work cell

I, _____, do hereby grant permission for the release of any and all information, written and/or verbal, regarding my medical condition, including, but not limited to treatment, history, financial obligations, and responsibilities to the following:

Person's Name	Relationship	Phone Number
Person's Name	Relationship	Phone Number
Person's Name	Relationship	Phone Number

___I give my permission to the practice to electronically download my medication history from the Internet database, and understand that it may not include some medications.

___I DO NOT give my permission for my medication history to be electronically downloaded.

I have reviewed the Notice of Privacy Practices of Milwaukee Sperm, MD, which explains how medical information will be protected, used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Legal Representative Date

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
Primary Care Physicians Name

_____
Address

_____
City State Zip

_____
Phone # Fax#

All Records Consultation Notes Lab Work Hospital Records/Discharge Pathology Reports

I hereby request that my medical records be released to:

Dr. Maninder Guram 506 Graham #230 Tomball, TX 77375

Phone: 281-205-7522 Fax: 281-205-7553

_____ / / _____
Patient's Name (print) Birth Date

_____
Address

_____
City State Zip

SS# _____ - _____ - _____

Patients Signature: _____ Date: _____

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ☐ I AM ADOPTED (No Medical History Available).

Social History

Are you capable of becoming pregnant? ☐ Yes ☐No *If so*, are you currently pregnant? ☐ Yes ☐No

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Current Alcoholism
☐ Never Drinks Alcohol ☐ Drinks Alcohol Socially

Tobacco Use: ☐ Current Tobacco User Packs Per Day_____ How many years smoker_____
☐ Former Tobacco User ☐ Has Never Used Tobacco

Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which: _____)
☐ Currently Uses Marijuana ☐ Currently Using Someone Else's Prescription Medications
☐ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐No (Which: _____)

PATIENT INTAKE FORM

Patient Name:_____

Weight:_____ B/P:_____ P:_____ Temp:_____ RR:_____

Date:_____

Please check (x) if you are experiencing or have any of the following:

General:
____Fatigue
____Fever
____Unintentional Weight Loss
____Unintentional weight Gain
____Daytime Somnolence
____Fogginess of Tasks
____Inability to Complete Tasks
____Insomia
____None Dry Mouth
____Visual Changes
____None

Cardiovascular:
____Chest Pain
____Palpitations
____None

Pulmonary:
____Snoring
____Shortness of breath
____Cough
____Obstructive sleep apnea
____Snore at night
____Use CPAP machine
____Smoker
____Chronic Obstructive
____Pulmonary Disease
____None

Gastrointestinal:
____Constipation:
____Diarrhea:
____Nausea:
____Heartburn:
____Blood in Stool:
____None

Genitourinary:
____Difficulty Urinating
____Painful Urination
____Blood in Urine
____Increased urinary frequency
____None

Endocrine:
____Heat Intolerance
____Cold Intolerance
____Increased Thirst
____None

Neurological:
____Glaucoma
____Difficulty Walking
____Headaches
____Numbness
____Seizures
____Strokes
____Weakness
____None

Musculoskeletal:
____Neck Pain
____Back Pain
____Muscle Aches
____Joint Pain
____Joint Swelling
____None

Hematologic:
____Clotting Difficulties
____Easy Bledding
____Easy Bruising
____None

Psychiatric:
____Depression
____Anxiety
____Thoughts harming oneself
____Thoughts harming others
____Hallucinations
____None

Other:
____Myocardial infarction
____Heart Attack
____Heart rhythm abnormalities
____Abnormal EKGS
____History of coronary stents
____Diabetes
____Steroid use
____Blood thinning medication
Example: Aspirin,Plavix,
Clopidogrel, Heparin,Lovenox
Other:_____
____None

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Glaucoma

Cardiovascular / Hematologic
- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke
- ❑ Coronary Artery Disease
- ❑ Pacemaker/Defibrillator

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic
- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy/CRPS
- ❑ Other Diagnosed Conditions

_____

Current Medications:

Please indicate which (if any) of the following blood-thinners you are taking:

____Aggrenox ____Lovenox ____Ticlid ____None
____Coumadin ____Plavix ____Warfarin
____Effient ____Pletal ____Xarelto
____Eliquis ____Pradaxa ____Other

Please List all medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency

Allergies:

Do you have any known drug allergies? ____YES ____NO

If so, please list all medications you are allergic to:

Medication Name	Allergic reaction type

Topical Allergies:

____Iodine ____latex ____Tape

Are you allergic to IV Contrast? ____YES ____NO

Any new medications:_____

Any new surgeries:_____

Any change in health:_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- ☐ Gallbladder removal _____
- ☐ Appendectomy _____
- ☐ Other _____

Female Surgeries

- ☐ Caesarean section _____
- ☐ Hysterectomy _____
- ☐ Laparoscopy _____
- ☐ Ovarian _____
- ☐ Other _____

Heart Surgery

- ☐ Valve replacement _____
- ☐ Aneurysm repair _____
- ☐ Stent placement _____
- ☐ Other _____

Joint Surgery

- ☐ Shoulder _____
- ☐ Hip _____
- ☐ Knee _____

Spine / Back Surgery

- ☐ Discectomy (levels) _____
- ☐ Laminectomy _____
- ☐ Spinal fusion (levels) _____

Other Common Surgeries

- ☐ Hemorrhoid surgery _____
- ☐ Hernia repair _____
- ☐ Thyroidectomy _____
- ☐ Tonsillectomy _____
- ☐ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

- ☐ MRI of the _____ Date: _____ Facility: _____
- ☐ X-ray of the _____ Date: _____ Facility: _____
- ☐ CT scan of the _____ Date: _____ Facility: _____
- ☐ EMG/NCV study of the _____ Date: _____ Facility: _____
- ☐ Other diagnostic testing: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

BioTE MEDICAL

Health Assessment for Men

Name: _____ Date: _____

E-Mail: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		

BioTE® MEDICAL

Health Assessment for Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		