Srinivas J. Madane, M.D.

Specialist in Diseases of the Stomach, Colon, Liver & Pancreas
Diplomate of the American Board of Internal Medicine
Gastroenterology and Hepatology

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Last Name: _____ First Name: _____ MI: _____

Address: _____
(Street) (City) (State) (Zip Code)

DOB: ___/___/___ Age: _____ Sex: ____ Marital Status: _____ SS#: _____ Self Pay: Yes/ No

Phone #: _____ Cell#: _____ Primary Care Physician: _____

Responsible Party (*If other than patient*): _____ DOB: ___/___/___

Address (*if different than patient*): _____
(Street) (City) (State) (Zip Code)

Emergency Contact: _____ Phone #: _____ Relationship _____

Pharmacy Name & Location: _____ Patient Email: _____

_____ Policy #: _____ Group#: _____
(Primary Insurance Company)

_____ Policy #: _____ Group#: _____
(Secondary Insurance Company)

Insurance Policy Holder Information:

Name of Insured: _____ Relationship: _____ DOB: ___/___/___

SS #: _____ Employer: _____ Work #: _____

Address: _____
(Street) (City) (State) (Zip Code)

I understand that I am financially responsible for any balance not covered by my insurance: _____
(Initial)

Is todays visit a ***Work*** related or an ***Auto*** related accident ? If YES, please fill out below:
Date of Accident: _____/_____/_____ Claim #: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Was Accident report filed with Employer/Auto Insurance? Yes/No

Billing Information:

Address of Workers Comp Insurance/Auto Insurance: _____

Name of Employer/Auto Insurance: _____ Work #: _____

Medical History

1. List any medications that you are **ALLERGIC** to: _____
2. List ALL **MEDICATIONS** and **SUPPLEMENTS** that you are presently taking:

3. Please check if you have any of the following:

☐ Diabetes	☐ Arthritis	☐ Hypertension	☐ GI Problems _____
☐ Hyperthyroidism	☐ Stroke	☐ Heart Disease	☐ Lung Problems _____
☐ Cancer _____		☐ Other _____	

4. Family History of any of the above (please List):
   - Mother: _____
   - Father: _____
   - Siblings: _____
   - Close Relatives: _____

5. Please indicate your past **SURGICAL HISTORY** with dates:

☐ Liver _____	☐ Tonsils _____	☐ Heart _____	☐ Appendectomy _____
☐ Gallbladder _____	☐ Breast _____	☐ Uterus _____	☐ Orthopedic _____
☐ Hemorrhoids _____	☐ Colon _____	☐ Other _____	

6. Social History:

Alcohol Use	Drug Use	Tobacco Use
☐ No How many drinks	☐ No	☐ No ☐ Cigarettes
☐ Current per week _____	☐ Current	☐ Current ☐ Smokeless tobacco
☐ Former per month _____	☐ Former	☐ Former ☐ Other
How many per occasion? _____	Name(s) _____	How many per day? _____

7. Colonoscopy (Dr, date, results): _____
8. Reason for Todays Visit: _____
9. How did you find out about us? _____
10. Covid Vaccinated _____ Or Not Vaccinated _____

I certify that the above information is correct. I authorize treatment for the above-named patient. I authorize payment of benefits to be made to Dr Madane.

I understand that my personal health information will be protected by HIPAA regulations and I give permission to provide the minimum necessary information for my treatment, billing or healthcare operations. I understand that I am free to revoke or amend this consent for future visits, and that I may request a detailed copy of the primary notice at any time. **Initialed**_____

I understand that I am financially responsible for any balance not covered by my insurance.

I accept the following terms and conditions:

*** A Fee of $35 will be charged on returned checks, for any reason.**

*** I will be liable for any collection cost involved, if becomes necessary.**

Patient_____ **Relationship**_____ **Date:** ____/____/____

(Signature)

Name:_____

Date:_____ Phone Number_____

Patient Questionnaire – Anorectal Health

Bowel & Dietary Habits

(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? _____Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**
7. Are you taking any fiber supplements? **Y / N**

a. If yes, which one(s)? _____

8. On average, do you drink the equivalent of 6-8 glasses of water per day? **Y / N**

Symptoms (in Rectal Area)

(Check all that apply)

☐ Bleeding ☐ Itching ☐ Prolapse

☐ Pressure or Swelling ☐ Leaking or Soiling ☐ Pain ☐ Burning

Additional Questions

(Circle either Yes or No for each answer)

1. Are you allergic to latex? **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any erectile dysfunction medicine for ED, any Viagra for hypertension, Cialis for your prostate or any nitrates for chest pain? **Y / N**
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**
6. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
7. Do you need to take antibiotics before having dental or other procedures? **Y / N**

Additional Comments?

_____

_____

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FINANCIAL POLICY

Name_____ Date of Birth _____

We are dedicated to provide out patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates:
We ask for your help by understanding and cooperating with our Financial Policy.

INSURANCES: We participate with several insurance companies. It is your responsibility to call your insurance company to verify if Dr. Madane is participating with you r insurance.

If we participate with your insurance company, all services performed will be submitted to your insurance's carrier. Any balances due from copays, coinsurances or deductibles are the patient's responsibility and are due at the time of service.

If we do not participate with your insurance company, all services performed will be submitted. If there are no out of network benefits you will be responsible for all fees at the time of service.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill is between you and your doctor.

Payments: All payments for copays and deductibles are due at the time of service. After insurance is billed any outstanding payments sue are expected within thirty days of receiving a patient statement. If payments are not paid the office may send any outstanding balances to a collection agency.

I HAVE READ AND FULLY UNDERSTAND AND THE FINANCIAL POLICY SET FORTH BY DR. SRINIVAS MADANE. I AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

_____ _____

Signature Date