PATIENT INFORMATION

Name (last)_____(first)_____(middle)_____

Address_____City_____St_____Zip_____

Home#_____Cell#_____Work#_____

SSN_____DOB_____Gender_____Marital Status _____

Employer_____Occupation_____

**Referring Physician_____Group Practice Name_____

Emergency Contact_____Relationship_____Phone#_____

Responsible party/Guarantor of minor patient_____

Relationship to minor patient_____SSN of Guarantor_____

INSURANCE INFORMATION

1st Primary Insurance _____Card Holder's Name_____

ID#_____Group#_____Card Holder's DOB_____

Card Holder's Address_____SSN_____

City_____State_____Zip_____Phone#_____Name of

Employer for Card Holder_____

2nd Secondary Insurance_____Card Holder's Name_____

ID#_____Group#_____Card Holder's DOB_____

Card Holder's Address_____SSN_____

City_____State_____Zip_____Phone#_____

Name of Employer for Card Holder_____

Please remember that insurance is filed as a courtesy for our patients. It is ultimately the patient's responsibility to ensure that insurance process their claim correctly. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. I hereby assign all medical and/or surgical benefits, including Medicare, private insurance, and other health plans to Muskogee Digestive Center, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment, To the extent necessary to determine liability for payment, I authorize disclosure of portions of the patient record, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and HIV, also known as AIDS, until otherwise revoked in writing by the patient or guardian.

Patient Signature_____Date_____

Privacy Procedures For

Muskogee Digestive Center, INC.

Our office recognizes and respects the patient's right to inspect and/or obtain a copy of their entire medical record and other protected health information in our possession.

- The front office staff will provide the patient a form to complete when the patient desires to inspect their information and/or request a copy of their information.
- The front office staff will answer all questions concerning the inspection and copying of medical and health information.
- All request to inspect, or for a copy of medical information, will be reviewed by the Office Manager before inspection or copying for completeness and correctness, including verification of the signature.
- This same procedure shall be followed for requests to change or correct a record, for disclosure of previous releases, and in response to a complaint.
- Recognizing that we have a "reasonable" amount of time to respond to a request for a copy of medical and health information, it is the policy of this office to attempt to respond within no more than seven to fourteen days.
- If access or copy is denied, the Office Manager shall provide the patient with a written explanation for the denial and outline the patient's right to appeal the decision.
- With regard to inspection by the patient: after the patients inspects the record, the Office Manager, or whichever front office staff member observed the inspection, will note in the record the time and date of inspection and whether or not any requests for amendments or changes to the record were made by the patient.
- In regard to the copy, the patient shall be advised in writing that this office charges the statutory copy cost of $1.00 for the first page and .50 cents for every page after, and if the copy is mailed, the actual cost of postage. No other charges are allowed by Oklahoma state law.

MUSKOGEE DIGESTIVE CENTER
384 S. 33RD STREET SUITE B
MUSKOGEE, OK 74401

I hereby authorize you to use or disclose information to the following recipients (eg. Spouse, relative, or friend).

_____

_____

_____

_____

_____

I understand that:

- *I may inspect of copy the protected health information to be used or disclosed*
- *I may revoke this authorization at any time*
- *Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA*
- *I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization*

Patient name(printed)_____

Name signed_____ ***date***_____

Muskogee Digestive Center, Inc.

Ajay K. Sangal, M.D.

Patient Name_____DOB____-_____-_____Date_____

Ref Phy_____Occupation_____Marital Status_____

Main Problem:

_____

_____

_____

HPI:

Do you have Abdominal Pain? Yes_____No_____ If Yes, answer the following:

How long_____Frequenccy_____

Where (upper/lower)_____

Severity (mild/mod./severe)_____

Quality (dull/cramping/sharp)_____

Related to meals/bowel habits, etc _____

_____

Do you have any of the following symptons:

	Yes	No	Details (For Doctor's Use)
Heartburn/Indigestion	☐	☐	_____
Nausea	☐	☐	_____
Vomiting	☐	☐	_____
Diff. In Swallowing	☐	☐	_____
Chest Pain	☐	☐	_____
Bloating/Gas	☐	☐	_____
Diarrhea	☐	☐	_____
Constipation	☐	☐	_____
Change in Bwl Hbts	☐	☐	_____
Ribbon like Stools	☐	☐	_____
Blood in Stools	☐	☐	_____
Mucous in Stools	☐	☐	_____
Black Stools	☐	☐	_____
Decreas in Appetite	☐	☐	_____
Loss of Weight	☐	☐	_____
Rectal Pain/Itching	☐	☐	_____
Abnormal Liver Test	☐	☐	_____

Past History: *Have you had any of the following, check if yes:*

HighBlood Pressure	☐	Colon Polyps	☐	Jaundice	☐
Heart Disease	☐	Peptic Ulcers	☐	Blood Transfusion	☐
High Cholesterol	☐	Cancer	☐	Tuberculosis	☐
Arthritis	☐	Hepatitis	☐	Asthma	☐

List any surgery/operations with dates:

1._____ 3._____
2._____ 4._____

Family History: Has anyone in your immediate family had any of the following, if yes, Check and specify relationship:

☐ Colon Polyps	_____	☐ Crohn's Disease	_____
☐ Colon Cancer	_____	☐ Ulcerative Colitis	_____
☐ Other Cancer	_____	☐ Diabetes	_____
☐ Peptic Ulcers	_____	☐ Heart Disease	_____
☐ Gallstones	_____	☐ Liver Disease	_____

Social History:

	Yes	No	How Much	For How Long
Smoke				
Drink Alcohol				
Drink Coffee				
Use Drugs				

List your medications and dosages:

1._____ 4._____
2._____ 5._____
3._____ 6._____
7._____ 8._____

List your drug allergies:

Review of systems: Do you have any of the following, check Yes or No"

	Y	N		Y	N		Y	N
Fever	☐	☐	Anemia	☐	☐	Depression	☐	☐
Cough	☐	☐	Easy Bruising	☐	☐	Diabetes	☐	☐
Shortness of Breath	☐	☐	Frequent headaches	☐	☐	Thyroid Problems	☐	☐
Blood in Urine	☐	☐	Seizures	☐	☐	Skin Rash/Itching	☐	☐
Prostate Problems	☐	☐	Strokes	☐	☐	Dble. Vision/Blurring	☐	☐
Joint Pains	☐	☐	Anxiety	☐	☐	Hearing Trouble	☐	☐
Milk Intolerance	☐	☐	Mentrual Irreg.	☐	☐	Weight Loss	☐	☐

Last Menstrual Period_____