ANESTHESIA 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			Shortness of Breath		
Glasses/ Contact Lenses			Any Problems with Sleep Apnea		
Aneurysms			Do you smoke/ Ever Smoked		
Seizures			Oxygen Dependent		
Black Outs (syncope)			-If yes, How much? _____		
Stroke			-Day & Night__ At night ONLY ____		
High Blood Pressure (even if controlled)			Hiatal Hernia/ Nausea/ Heartburn		
Heart Problems:			Family History of:		
Heart Attack			**Colon Cancer**		
Chest Pain			**Esophageal Cancer**		
Irregular Heartbeat/Palpitations			**Stomach Cancer**		
Heart Failure			Diabetes		
Heart Surgery			Thyroid Trouble		
Heart Valve Problems			Blood Clotting Problems		
Heart Stents If yes, Date: _____			History of Bleeding/ Anemia		
Do you have a pacemaker			Sickle Cell Disease		
Pacemaker with Defibrillator Brand: _____			Any Neck or Back Problem		
Cardiac Cath in the last 18 months: (ultrasound/x-ray of the heart) Test completed @: _____			Are you pregnant now		
			Kidney Trouble		
			Are you on dialysis		
Stress test in last 18 months: Test completed @: _____			Autoimmune Disease: Lupus or Rheumatoid Arthritis/other		
			History of Anxiety/Depression		
HEIGHT: _____ WEIGHT: _____			Other Problems not mentioned?		

Drug/Latex/Tape Allergies: _____

Current Medications: _____

_____

_____

Prior Surgeries (include year): _____

_____

_____

_____

Primary Care Physician/ Family Physician:

_____

PRINT Patient Name

_____

Patient Sign

Lake Gastroenterology Associates

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

1858 Mayo Drive, Tavares, FL 32778
10900 S.E. 174th Place, Summerfield, FL 34491

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 ____/____/____

PATINET 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)

PLEASE FILL OUT INSURANCE INFORMATION IF SUBSCRIBER IS SOMEONE OTHER THAN PATIENT

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 _____

ADDRESS _____
STREET CITY STATE ZIP

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

Lake Gastroenterology Associates

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

History & Physical

DATE _____/_____/_____

PATIENT'S NAME

DATE OF BIRTH _____

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE AND INDICATE WHICH RELEATIVE

1) HEPATITIS 2) CANCER 3) COLON POLYPS 4) COLITIS

HOSPITAL ADMISSIONS (NOT INCLUDING PREGNACIES)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST OF MEDICATIONS YOU ARE NOW TAKING

ALLERGIES _____

MEDICAL HISTORY CHECK AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES

o Shortness of Breath	o Heartburn	o Diverticulosis	o IVDA/Illicit Drugs
o Chest Pain	o Persistent Nausea	o Bloody or Tarry Stools	o Tattoos
o High Blood Pressure	o Abdominal Pain-Chronic	o Hemorrhoids	o Cancer
o Heart Murmur	o Gall Bladder trouble	o Weight Loss	o Diabetes
o Loss of Appetite-recent	o Jaundice/ Hepatitis	o Anemia	o Alcohol ____ oz. per week
o Difficulty Swallowing	o Diarrhea/ Vomiting	o Blood Transfusions	o Smoking _____ cig/day

Is there any organ/part on your body that you do not want doctor to examine: Breast/Pelvis/Genitals/Rectum

SUMMARY OF MEDICAL PROBLEMS

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 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.

PATEINT NAME (PRINT) _____

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN (PLEASE PRINT) _____ SIGNATURE _____

Lake Gastroenterology Associates
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10900 S.E. 174th Place, Summerfield, FL 34491
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 Practiced 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:

_____