PATIENT INFORMATION

483 N Semoran Blvd
Suite #101
Winter Park, FL 32792-3800

FLORIDA GASTROENTEROLOGY/GUARDIAN HEALTH SOLUTIONS LLC

Date:_____

SSN: _____Sex: *Male/Female* Marital Status: *Single/Married/Divorced/Widowed*
Date of Birth: _____Age: _____
First Name: _____Middle: _____Last: _____
Home phone: _____Cell phone: _____Work phone: _____
Address:_____City:_____State:_____Zip:_____
Current Employment Status: *Full-time/Part-time/Retired/Unemployed*
Employer:_____Address: _____City:_____Zip:____

Name of Doctor/Person who referred you to Dr. Bajaj:_____

Name of person to notify in case of emergency:_____Phone:_____
Relationship to contact: _____

INSURANCE INFORMATION

WE WILL NEED YOUR CURRENT INSURANCE ARD AND DRIVERS LICENSE PLEASE GIVE IT TO THE RECEPTIONIST TO MAKE COPIES

Do you have Medicare: ☐Y ☐ N #_____Medicaid: ☐Y ☐ N #_____

PRIMARY INSURANCE

Company:_____Address:_____
Member ID#:_____Group #:_____
Subscriber: ☐ Self ☐ Spouse ☐ Guardian
Subscriber's Name: _____DOB:_____
Address: _____

SECONDARY INSURANCE

Company:_____Address:_____
Member ID#:_____Group #:_____
Subscriber: ☐ Self ☐ Spouse ☐ Guardian
Subscriber's Name: _____DOB:_____
Address: _____

I understand and agree, I will be responsible for the payment of the charges incurred on behalf of myself or family member.

PATIENT METHOD OF DISCOLSURES-The HIPPA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ OK to leave messages with detail information on HOME/CELL/WORK Phone
☐ Home Telephone: _____☐Cell phone_____☐Work phone_____
☐ OK to e-mail_____
☐OK to mail to my home address ☐ OK to leave message with call back number only
Person/Persons who are allowed to obtain your Health Information:_____
_____

ASSIGNMENT OF BENEFITS/MEDICAL REALEASE

I request that payment of authorized benefits be made for any services furnished to me by Florida Gastroenterology/Guardian Health Solutions LLC of its legal subsidiaries, affiliates, successor and assigns. If my current policy prohibits direct payment to the provider, I hereby acknowledge that I am responsible for submitting payments received to the provider for services furnished to me by the provider. I also understand that I am financially responsible for services not covered by benefits. I authorize any holder of medical or other information about me to release information needed to any person, accreting or certifying/professional organizations company and/or agency which is or may be liable for any portion of the payment of the changes for such services, ore performing audits. In addition, I authorize Florida Gastroenterology/Guardian Health Solution LLC to request and obtain any necessary medical reports necessary for comparison purposes associated with my treatment.
I acknowledge that I have received Florida Gastroenterology/Guardian Health Solutions LLC Notice of Privacy Acts.

Patient Signature:_____Date:_____

FLORIDA GASTROENTEROLOGY, P.A.
PATIENT MEDICATION FORM

Patient Name: _____ DOB : _____ Today's Date: _____

Pharmacy (preferred): _____ Pharmacy phone # : _____

Please complete the following form in detail prior to your appointment and bring this form with you. Be sure t include ALL MEDICATIONS INCLUDING VITAMINS, HERBS AND OVER THE COUNTER DRUGS (ASPIRIN ETC AS WELL AS YOUR PRESCRIPTION DRUGS AND THE AMOUNT AND FREQUENCY YOU TAKE THEM.

If you are unable to complete this form, please bring all your medications to your appointment and someone wi assist you to fill out this form.

	NAME OF MEDICATION	DOSAGES/STRENGTH	DIRECTIONS/HOW OFTEN USED
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

ALLERGIES

Drug	Reaction	Drug	Reaction

FLORIDA GASTROENTEROLOGY, P.A.

PLEASE DESCRIBE THE REASON YOU ARE SEEING THE PHYSICIAN TODAY: _____

_____

Past Medical History - Patient Name: _____ Date: _____

Please check if you have ever had problems with the following:

- ☐ Heart Disease
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker/Defibrillator
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Lungs/Breathing Difficulties
- ☐ Pulmonary Embolism
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Clots/Bleeding Problems
- ☐ HIV
- ☐ Hepatitis
- ☐ Varicose Veins
- ☐ Back Problems
- ☐ Parkinson's
- ☐ Arthritis
- ☐ Paralysis
- ☐ Fainting
- ☐ Headaches
- ☐ Seizure
- ☐ Stroke or mini-stroke
- ☐ Dizziness/Falling
- ☐ Glaucoma [R] [L]
- ☐ Cataracts [R] [L]
- ☐ HOH
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Heartburn/Indigestion
- ☐ GERD/ Hiatal Hernia
- ☐ Gallstones
- ☐ Liver Problems
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Prostate Problems
- ☐ Pancreatitis
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
  Where? _____
- ☐ Recreational Drug Use

Other: _____

Past Surgical History

Please check all previous surgeries that you have had:

- ☐ Abdominal Surgery
- ☐ Appendectomy
- ☐ Colon Surgery
- ☐ Gall Bladder Surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia [R] [L]
- ☐ Hiatal Hernia Repair
- ☐ Breast/Mastectomy [R] [L]
- ☐ Angioplasty/Stent Placement
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Arm/Hand/Foot [R] [L]
- ☐ Neck/Back Surger
- ☐ Hip Surgery [R] [L]
- ☐ Knee Surgery [R] [L]
- ☐ Shoulder Surgery [R] [L]
- ☐ Cesarean
- ☐ D&C
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Eye / Cataract [R] [L]
- ☐ Tonsillectomy
- ☐ Colonoscopy
- ☐ Endoscopy
- ☐ Flex Sig
- ☐ Barium Enema

Year of Procedure _____

ALLERGIES

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

Other: _____

List all Medications - Prescription and Non-Prescription drugs including Vitamins/Supplements and Herbal remedies

_____

_____

OFFICE USE ONLY Patient Signature _____ **Date** _____

ASA STATUS Airway: MP I II III IV Neck: FROM LROM _____ H/O Difficult Intubation Y N Teeth _____

Respiratory: LCTA: Y N _____ Cardiac: S1 S11 S111 RR IR Murmur Y N _____

1 2 3 4 E NPO Y N _____ Other Significant Exam Findings: _____

FAMILY HX

1) ☐ EPLEPSY	6) ☐ ARTHRITIS	11) ☐ CELIAC DIS	16) ☐ COLITIS
2) ☐ STROKE	7) ☐ KIDNEY DIS	12) ☐ CANCER	17) ☐ CROHNS
3) ☐ MENTAL DIS	8) ☐ ANEMIA	13) ☐ COL CANCER	18) ☐ PANR
4) ☐ DIABETES	9) ☐ HEART DIS	14) ☐ POLYPS	19) ☐ LIVER DIS
5) ☐ ASTHMA	10) ☐ HYPERT	15) ☐ PUD	

Pre Anesthesia Orders:

Consent completed

IV Saline at KVO Rrate

Post Anesthesia Orders:

Monitor patient with Pulse Oximeter. If O2 saturation drops below 92% place on supplemental O2

VS Q 15 minutes if stable

PO Fluids as tolerated

PLAN: ☐ General anesthesia ☐ Subarachnoid Block ☐ Epidural ☐ Regional ☐ Monitored Anesthesia Care ☐ Risks / procedures / benefits / options of anesthesia discussed with patient or patients representative who understands and accepts. All questions answered.

Signature _____ Date _____