SINGARAM GASTROENTEROLOGY

PATIENT REGISTRATION INFORMATION

PATIENT'S PERSONAL INFORMATION

First & Last Name: _____ Middle Initial _____

How do you wish to be addressed? _____ Gender _____

Date of Birth: ____/____/____ Social Security # ____-____-____

Street Address: _____ (Apt # _____)

City: _____ State: _____ Zip: _____ Phone: ☐Home ☐Cell ☐Work (____) _____

Email: _____ Phone: ☐Home ☐Cell ☐Work (____) _____

Spouse's Name: _____ Spouse's phone: (____) _____

PATIENT'S / RESPONSIBLE PARTY INFORMATION : ☐Self ☐Spouse ☐Parent ☐Other _____

Responsible party's name (if not yourself): _____

Date of Birth: ____/____/____ Social Security # ____-____-____

Street Address: _____ (Apt # _____)

City: _____ State: _____ Zip: _____ Phone: ☐Home ☐Cell ☐Work (____) _____

PATIENT'S INSURANCE INFORMATION *Please present insurance cards to the receptionist.* ☐ Copy made

Primary Insurance company's name: _____ Policy Holder (PH): _____

PH Date of Birth: ____/____/____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

PH's Social Security # ____-____-____ Copay amount: $_____

Insurance ID # _____ Group number: _____

Is your condition a result of an injury?

Work? ☐ Yes ☐ No An auto accident? ☐Yes ☐No Date of injury: ____/____/____

PATIENT'S REFERRAL INFORMATION ☐Website ☐Google search ☐Facebook ☐Other _____

Referred by: _____ If referred by a friend, may we thank them? ☐ Yes ☐ No

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ☐Home ☐Cell ☐Work (____) _____ Phone: ☐Home ☐Cell ☐Work (____) _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance to be made directly to Singaram Gastroenterology, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

SINGARAM GASTROENTEROLOGY

PATIENT HISTORY FORM

Name: _____ DOB: _____ Today's Date _____
Referring Physician: _____ Primary Care Provider: _____
Reason for your visit today: _____
Pharmacy Name and Location: _____

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 30 DAYS:

- ☐ No symptoms
- ☐ Acid reflux
- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Recent weight changes
- ☐ Nausea
- ☐ Vomiting
- ☐ Fatigue
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal cramping
- ☐ Blood in stool
- ☐ Fecal incontinence
- ☐ Belching or gas
- ☐ Other _____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE:

(Include over the counter medication and supplements)

1. _____ Dose: _____ Instructions: _____
2. _____ Dose: _____ Instructions: _____
3. _____ Dose: _____ Instructions: _____
4. _____ Dose: _____ Instructions: _____
5. _____ Dose: _____ Instructions: _____
6. _____ Dose: _____ Instructions: _____
7. _____ Dose: _____ Instructions: _____
8. _____ Dose: _____ Instructions: _____
9. _____ Dose: _____ Instructions: _____
10. _____ Dose: _____ Instructions: _____

List all medication allergies: _____

Date of last EGD _____ Any abnormal findings? _____ Facility: _____
Date of last colonoscopy _____ Any abnormal findings? _____ Facility: _____
Past Surgical History (include dates): _____

List all Current Medical Diagnoses: _____

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Who lives with you? _____
Employer / Occupation: _____ What type of work? _____
Do you drink alcohol? ☐ Never ☐ Less Than Once Per Month ☐ Monthly ☐ Weekly ☐ Daily
Do you or have you ever use: ☐ Tobacco ☐ Nicotine products ☐ Vape
What is your current usage/ frequency? _____ Quit date for previous Use: _____

FAMILY MEDICAL HISTORY

Please list medical conditions for immediate family members.

Mother: _____ Father: _____
Brothers/ Sisters: _____

FAMILY ILLNESSES:

History of Polyps of Colon Cancer ☐ Mother ☐ Father ☐ Brothers/Sisters Age of Onset _____
History of heart disease? ☐ Yes ☐No History of high blood pressure? ☐ Yes ☐No
History of strokes? ☐ Yes ☐No History of diabetes? ☐ Yes ☐No

Does anyone in the family have a history of esophageal, stomach, pancreatic, gallbladder, intestinal, or liver cancers? ☐ Yes ☐No
If yes, please describe:

SINGARAM
GASTROENTEROLOGY

Reassurance. Relief. Recovery.

HIPAA ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As states in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Official at Gastroenterology – A Division of Midwest Medical Care.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices date April 14, 2003.

Name of Patient: _____
Print

Date of Birth: _____ Date: _____

Patient or Patient Representative: _____
Signature

Is there anyone you would like us to share your medical records with?

Name: _____ Phone: _____

Relationship: _____

MIDWEST MEDICAL CARE, PC

DISCLOSURE OF OWNERSHIP INTEREST - SIOUX FALLS SPECIALTY HOSPITAL
NOTICE TO PATIENTS

As a prospective patient at Sioux Falls Specialty Hospital, it is important that you read and understand the following disclosure prior to scheduling any procedure at the Sioux Falls Specialty Hospital. If you have any questions, please feel free to speak with your physician or a member of the staff at the Sioux Falls Specialty Hospital:

DISCLOSURE OF PHYSICIAN OWNERSHIP

1. The Sioux Falls Specialty Hospital is partially owned by physicians and meets the federal definition of a physician owned hospital as specified in 42 CFR 489.3.

2. Your physicians and/or the physician's immediate family members have the following ownership interest in the Sioux Falls Specialty Hospital: 1.5%

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the Sioux Falls Specialty Hospital.

4. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of the Sioux Falls Specialty Hospital.

Acknowledgment of Disclosure

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership.

_____ _____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____ _____

Print Name of Patient Print Name of Parent or Guardian (if applicable)

_____

Date