Dr. Vijaya M. Dasari
North Texas Gastroenterology, PA

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Patient Name: _____ _____ _____
Last First Middle

_____ _____ _____ _____
Date of Birth Social Security # Home Cell

_____ _____ _____ _____
Mailing Adress City State Zip

_____ Sex: ☐M ☐F _____ _____
Email Race Language

Marital Status: ☐Married ☐Widowed ☐Single ☐Divorced ☐Separated

Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student

_____ _____
Local Pharmacy & Location Mail Order Pharmacy

_____ _____
Referring Physician & Phone # Primary Care Physician & Phone #

_____ _____ _____
Emergency Contact Phone # Relationship

_____ _____ _____
Insurance Name Policy Holders Name Policy Holder's DOB

I understand that if any of the insurance information I have provided, is incorrect, if I fail to notify NTG of any insurance changes, or do not make sure I have a referral that is needed, that I am responsible for all charges. I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize my insurance company to directly pay NTG. If my insurance company does not pay, I understand that I will be responsible for payment. I understand that NTG may have a vested insterest in the facility where my preocdures are performed. I agree to call NTG if my test results have not been called to me within two weeks of the completion of my test.

Patient Signature _____ Date _____

Name _____ Date_____

## HEALTH HISTORY QUESTIONNAIRE

**Are you being seen for any of the following? Check all that apply.**

- ☐ Change in appetite
- ☐ Weight loss
  How Much _____ Over what period of time _____
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Anemia
- ☐ Vomiting Blood
- ☐ Black tarry stools
- ☐ Rectal bleed/Bloody stools
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Constipation
- ☐ Changes in bowel habits

Other: _____

**Have you ever been diagnosed with any of the following? Check all that apply.**

- ☐ Hepatitis
- ☐ Seizures
- ☐ Stroke
- ☐ Anxiety/Depression
- ☐ Nervousness/Panic attacks
- ☐ Ulcers
- ☐ Colitis
- ☐ Colon polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's Disease
- ☐ Spastic Colon
- ☐ Gerd
- ☐ Celiac Disease
- ☐ Barrett's
- ☐ Colon Cancer
- ☐ Gallstones
- ☐ Excessive scar tissue/Adhesions
- ☐ Cancer What kind _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Irregular heartbeat
- ☐ Valvular heart disease
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus trouble
- ☐ Allergies
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Blood clot in lung
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Poor circulation
- ☐ Blood clot in leg
- ☐ Arthritis
- ☐ Genital disorders
- ☐ Prostate problems
- ☐ Pelvic infections
- ☐ Kidney stones

Other Medical Problems: _____

_____

**Are you allergic to any medications?** If yes, please list them _____

_____

_____

_____

_____

**Last Colonoscopy** _____

**Last Flu Shot** _____

**Last Pneumonia Shot** _____

**Height** _____

**Weight** _____

**Turn Over**

Have you ever had any of the following operations? Other surgeries:_____

- ☐ Removal of part / all of stomach
- ☐ Removal of part / all of colon
- ☐ Removal of gallbladder
- ☐ Removal of appendix
- ☐ Removal of spleen
- ☐ Hemorrhoid surgery
- ☐ Hernia surgery
- ☐ Replacement of heart valve
- ☐ Heart Bypass
- ☐ Heart Catheterization
- ☐ "Roto-Rooter" of blood vessels
- ☐ Artificial blood vessel graft
- ☐ Prostate surgery
- ☐ Hysterectomy
- ☐ Tubaligation
- ☐ Removal of kidney
- ☐ Placement of artificial joint
- ☐ Tonsillectomy
- ☐ Eye surgery
- ☐ Knee Replacement

**Tobacco Use**

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Smoker
- ☐ Chewing Tobacco
- ☐ Snuff

**Caffeine Use**

- ☐ Coffee
- ☐ Tea
- ☐ Carbonated Beverages
- ☐ No Caffeine Use

**Alcohol Use**

- ☐ Occasional
- ☐ Moderate
- ☐ Heavy
- ☐ Beer
- ☐ Wine
- ☐ Hard Liqour

Drug use_____

**What medications do you take?**

| **Medication** | **Mg** | **How Often** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Family history of medical problems**

Mother (1) Father (2) Sister (3) Brother (4) Mother's Mother (5) Mother's Father (6) Father's Mother (7) Father's Father (8)

| | | | | | |
|---|---|---|---|---|---|
| Colitis | _____ | Crohn's disease | _____ | Diabetes | _____ |
| Celiac disease | _____ | Gastric cancer | _____ | Hypertension | _____ |
| Esophagel cancer | _____ | Liver cancer | _____ | High Cholesterol | _____ |
| Pancreatic cancer | _____ | Stomach cancer | _____ | Heart disease | _____ |
| Colon cancer | _____ | | | Lung disease | _____ |

Other:_____

**Check any of the following you are currently experiencing:**

| | | | | |
|---|---|---|---|---|
| ☐ Chills | ☐ Blurred Vision | ☐ Swollen Glands | ☐ Belching | ☐ Dizziness |
| ☐ Fatigue | ☐ Choking Sensation | ☐ Chronic Cough | ☐ Bloating | ☐ Headaches |
| ☐ Fever | ☐ Hoarseness | ☐ Chest Pain | ☐ Chronic Diarrhea | ☐ Cold/Heat Intolerance |
| ☐ Night Sweats | ☐ Sore Throat | ☐ Shortness of Breath | ☐ Back Pain | ☐ Excessive Thirst |
| ☐ Itchy Skin | ☐ Voice Changes | ☐ Swelling of Extremities | ☐ Joint Pain | ☐ Easy Bruising |

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**HIPAA Information and Consent Form**

The Health Insurance and Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "short" version. A full version is posted in the office, and available upon request. There are rules and restrictions on who may have access to your Protected Health Information (PHI). HIPAA provides certain rights and protections to you as the patient.

As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided in our office, but also disclosures for your health information may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third party payers or insurers for claims review, determination of benefits and payments; our submission of your health information to auditors hired by third party payers and insurer, among other aspects or payment described in our Notice of Privacy Practices.

We may call patients in the waiting room when it is time for them to go to an examining room. To do this, we may use your first and/or last name.

It is the policy of this office to remind patients for their appointments. We may have to contact you to provide appointment reminders or to have you contact the office. To do this, we may mail you letters in envelopes with our practice name and return address, call you at your home or work, or leave messages with family members or voicemail.

You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. You must request restrictions in writing. However, we are not obligated to alter internal policies to conform to your request.

By signing this consent you signify that you agree that all payments are deemed your responsibility and are due at the time of service, unless prior arrangement have been made, or you have insurance coverage in which you have provided copies for filing purposes.

My signature on this form will serve as "SIGNATURE ON FILE" for processing any applicable insurance claims. I understand that my insurance may deny benefits if determined I received an examination too frequently or received examinations by separate doctors by the same illness. I agree to pay for the services that my insurance deems my responsibility.

I agree to pay my Copay, co-insurance, and or deductible at the time of services rendered. I also understand that all costs are estimated and that the insurance will make the final determination in the amount that I am responsible for.

By signing this consent, you signify that you agree that we can, will use, and disclose your health information to treat and to obtain payment for our services rendered to you.
**We may decline treatment should you refuse to sign this consent.**

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature _____ Date _____