Gastroenterology Care
Kishore Maganty, MD
Patient information sheet

Name: _____ **Date**: _____

Address: _____ **City**: _____**Zip**_____ **Date of Birth**: _____

Phone number: _____ **Email**: _____

Last 4 of SSN: _____ **Primary care physician**: _____

Reason for visit (list symptoms): _____

Pharmacy name: _____ **Phone number**: _____

Current Medications (attach if needed):

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

List any blood thinners (including aspirin):_____

Drug allergies: _____

Medical History: ☐ None

☐ High blood pressure ☐ Diabetes ☐ High cholesterol ☐ Thyroid disease ☐ COPD

☐ Heart stent(s) ☐ Heart failure ☐ Atrial fibrillation ☐ Pacemaker ☐ Defibrillator

Surgical history: ☐ Gallbladder ☐ Appendix ☐ Intestinal or colon surgery ☐ Hysterectomy

Do you smoke: ☐ Yes ☐ No ____ Years of smoking Packs per day: _____

Do you drink alcohol: ☐ Daily ☐ Weekends ☐ Socially ☐ Rarely

Family history: ☐ Colon cancer ☐ Liver disease ☐ Crohns disease ☐ Colitis ☐ Pancreatic cancer

Last colonoscopy: _____ (month/year) Location: _____

Findings: _____

Last endoscopy: _____ (month/year) Location: _____

Findings: _____

Last EUS or ERCP: _____ (month/year) Location: _____

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CT scan: _____ (month/year) Location: _____

Ultrasound scan: _____ (month/year) Location: _____

Insurance Info – Please also provide insurance cards for copies

Primary Insurance _____ Member ID _____

Group # _____ Name of Insured _____ Rel. to Patient_____

Secondary Insurance _____ Member ID _____

Group # _____ Name of Insured _____ Rel. to Patient_____

Assignment of Insurance Information & Benefits/Release of Medical Information: I hereby authorize Gastroenterology Care LLC to administer/perform any medical and or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to Gastroenterology Care LLC. Furthermore, I understand that I am responsible for all co-pays/co-insurance/deductibles and/or charges incurred that are not covered in full by my insurance. I hereby authorize the release of all applicable medical information, including & without limitation, copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent care or treatment in connection with care provided by Gastroenterology Care LLC.

Signature of Responsible Party _____ Date _____