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 _____

H.I.P.A.A. CONSENT

Authorization to Release PHI

Patient Name: _____

Date of birth: _____ Date: _____

To give consent to disclose health care information to someone OTHER than the patient, please write their name below: (ex: Family member, caretaker, close friend)

1: _____ relation: _____

2: _____ relation: _____

3: _____ relation: _____

4: _____ relation: _____

_____ I understand that signing this document means that Gastroenterology Care LLC may use and disclose my Personal Health Information (PHI) to help provide health care to me, to handle billing and payment, and to take care of other health care options.

_____ Under the terms of consent, I can ask Gastroenterology Care LLC to restrict how my PHI is used or disclosed to carry out treatment, payment, or health care operations. I understand that Gastroenterology Care LLC does not have to agree with my request. If Gastroenterology Care LLC agrees, I understand that the agreed limits will be followed.

_____ I understand that I have the right to cancel this consent, in writing or update of this form, at any time. If I do cancel this consent, I understand that Gastroenterology Care LLC may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

_____

Patient name(Printed)

_____ _____

Patient Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kishore Maganty, MD
Gastroenterology
522 N New Ballas Rd, Ste 210
St. Louis, MO 63141
Phone: 314-328-5930 | Fax: 314-328-5933

Patient Information

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____

Acknowledgment

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Kishore Maganty, MD. This Notice explains how my protected health information may be used and disclosed and describes my rights regarding that information.

I understand that I may request a paper copy of the Notice of Privacy Practices at any time.

Patient or Legal Representative Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient, if Applicable: _____

Office Use Only — If Patient or Representative Declines to Sign

I certify that the patient or legal representative was offered a copy of the Notice of Privacy Practices but declined or was unable to sign this acknowledgment.

Reason:

Staff Member Signature:
Printed Name:
Date: