CONSULTANTS IN GASTROENTEROLOGY - REGISTRATION SHEET
PHONE: (219) 922-3040 • FAX: (219) 922-3048

ACCT#:_____

☐701 Superior Ave., Ste. G Munster, IN 46321 (All physicians)	☐9660 Wicker Ave. St. John, IN 46373 (Dr. Cahan/Dr. Herbstman)	☐16000 W. 101st Ave. Dyer, IN 46311 (Dr. Kniaz)	☐5500 Hohman Ave., Ste. 2A Hammond, IN 46320 (Dr. Lodhi/Dr. Appannagari)	☐2075 Indianapolis Blvd. Whiting, IN 46394 (Dr. Nallapareddy)

LAST NAME:	FIRST NAME / INITIAL:		
D.O.B.:	PATIENT SS#:		SEX: M / F
ADDRESS:	CITY:	STATE:	ZIP:
HOME #:	CELL #:	WORK #:	
EMAIL ADDRESS:			
MARITAL STATUS: S M SEP D W	LANGUAGE:		RACE:
ETHNICITY:	REFERRED BY:		
SPOUSE'S NAME:	CELL #:	WORK #:	

RESPONSIBLE PARTY / GUARANTOR

RESPONSIBLE PARTY NAME:		
D.O.B.:	SS#:	SEX: M / F
HOME #:	CELL #:	

EMERGENCY CONTACT INFORMATION

NEAREST RELATIVE NOT LIVING WITH YOU:	
HOME #:	CELL #:

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
INS. CO:		INS. CO:	
ID #	GRP #:	ID #	GRP #:
POLICY HOLDER NAME:		POLICY HOLDER NAME:	
POLICY HOLDER SS#:	D.O.B.:	POLICY HOLDER SS#:	D.O.B.:
ADDRESS:		ADDRESS:	

DID YOU SUSTAIN AN INJURY AT WORK? Y N	ARE YOUR INJURIES ACCIDENT RELATED? Y N
ARE YOU COVERED UNDER AN EMPLOYER/UNION POLICY? Y N	

**PLEASE SIGN BACK PAGE -->

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information / Medical Record Diagnosis – I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediate responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving them written notice. I understand that if I refuse to consent to the release of information, I will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to , the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare Part B. I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason should it be necessary on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I understand that services rendered to me by Consultants in Gastroenterology are my financial responsibility and that the provider will bill my insurance company as a courtesy. I have provided all relevant and accurate information to facilitate the prompt payment. I authorize my insurance company to pay my benefits directly to Consultants in Gastroenterology and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a timely manner, any balance of said professional service charges over and above the insurance payment. I understand that if I do not pay the balance in full my account will be placed for collections and I will be responsible for all collection expenses including reasonable attorney's fees and court cost. I also understand that there will be a **$35 fee** for any check returned for any reason from my bank.

Co-Payments – I understand that if my medical insurance requires a copay or encounter fee the payment is due **AT THE TIME OF SERVICE**

No Show Policy – Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for those occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$35 no show fee**. As of December 1, 2010, you must **give 24 hour advance notice** to cancel appointments. Failure to do so will result in a **$35 fee charged to your account.** By signing below, I acknowledge that I have read and understand this policy.

REFERRALS / AUTHORIZATIONS – It is the responsibility of the patient to obtain any referrals needed for office visits. Our office will obtain precertification for procedures. It is the patient's responsibility to know their benefits.

In accordance with the Telephone Consumer Protection Act, I give permission to be contacted by automated phone calls for the purpose of appointment reminders and collecting any outstanding balances.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

_____ _ _____

Patient Signature Date Responsible party Signature

I authorization for the medical, or billing staff of my physician's office to release information regarding my medical care to:

_____(name/relationship) _____(name/relationship)

_____(name/relationship) _____(name/relationship)

CONSULTANTS IN GASTROENTEROLOGY

PATIENT INTAKE INFORMATION (PLEASE PRINT)

Patient name: _____ **D.O.B.:** _____ **Date:** _____

Reason for visit: _____

Name of Pharmacy and city: **local:** _____ **mail order:** _____

Name of Lab/imaging facility/Hospital you use: _____

Name of Primary Care Physician: _____

Name of Referring Doctor: _____

Allergies:

Drug / Allergen: _____

Reaction: _____

Gynecologist History: (FEMALE ONLY)

Date of last menstrual period: _____

Family History: (Please Circle)

Mother: Alive / Deceased - Age _____ Age of Death _____

Health History/ cause of death _____

Father : Alive / Deceased - Age _____ Age of Death _____

Health History/ cause of death _____

Family History of Colon Cancer / Polyps or Breast Cancer: _____

Social History - please circle

Smoking - never - former - current every day - current some days

Smoking - None - 1PPW - 2PPW - 1/4 PPD - 1/2 PPD - 1 PPD - 1 1/2 PPD - 2 PPD - 3+ PPD

Has smoked since age: _____

Diet - regular - vegetarian - vegan - gluten free - specific - carbohydrate - cardiac

Alcohol intake - none - occasional - moderate - heavy

Chewing Tobacco - none - 1 per day - 2 -4 per day - 5+ per day

Surgical History:

Procedure/ Date: _____

_____

CONSULTANTS IN GASTROENTEROLOGY

Name: _____ **Acct #:** _____

Past Medical History - please circle:

Angina (chest pain)	Y	N	Hoarseness	Y	N
Anxiety Disorder	Y	N	Hypertension	Y	N
Arthritis	Y	N	Hyperthyroidism	Y	N
Asthma	Y	N	Hypothyroidism	Y	N
Backaches	Y	N	Incontinence (leakage of urine)	Y	N
Bronchitis	Y	N	Insomnia	Y	N
CABG (heart bypass surgery)	Y	N	Irregular pulse	Y	N
COPD	Y	N	Jaundice	Y	N
Cancer	Y	N	Joint pain/stiffness	Y	N
Cataracts	Y	N	Kidney Disease	Y	N
Cirrhosis	Y	N	Kidney Stones	Y	N
Colonoscopy	Y	N Year: _____	Liver Disease	Y	N
CAD (coronary artery disease)	Y	N	MVP (mitral valve prolapse)	Y	N
Cough	Y	N	Muscle Pain	Y	N
Depression	Y	N	Nervousness	Y	N
Diabetes	Y	N	Nocturia (urinate at night)	Y	N
Diverticulitis	Y	N	Numbness	Y	N
Dyspnea (shortness of breath)	Y	N	OM (otitis media)	Y	N
EGD (Endoscopy)	Y	N Year: _____	Osteoporosis	Y	N
Edema	Y	N	Pacemaker/Defib	Y	N
Emphysema	Y	N	Palpitations	Y	N
Fainting	Y	N	Paralysis	Y	N
Fatigue	Y	N	Polyps	Y	N
Fibromyalgia	Y	N	Pulmonary Embolism	Y	N
Fractures	Y	N	STD discharge	Y	N
Frequent sore throats	Y	N	Seizures	Y	N
Frequent/painful urination	Y	N	Stroke	Y	N
GERD/Reflux	Y	N	Swelling	Y	N
Glaucoma	Y	N	Tingling	Y	N
Gout	Y	N	Tinnitus (ringing in ears)	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Heart Disease	Y	N	UTI (urinary tract infection)	Y	N
Hemauria (blood in urine)	Y	N	Vertigo	Y	N
Hemopysis (cough up blood)	Y	N	Weakness	Y	N
Hepatitis A B C	Y	N	Weight gain	Y	N
Hernias	Y	N	Weight loss	Y	N
High Cholesterol	Y	N			

CONSULTANTS IN GASTROENTEROLOGY

Name: _____ **Acct #:** _____

List of current medications including vitamins:
(if you have a list, please give it to our staff)

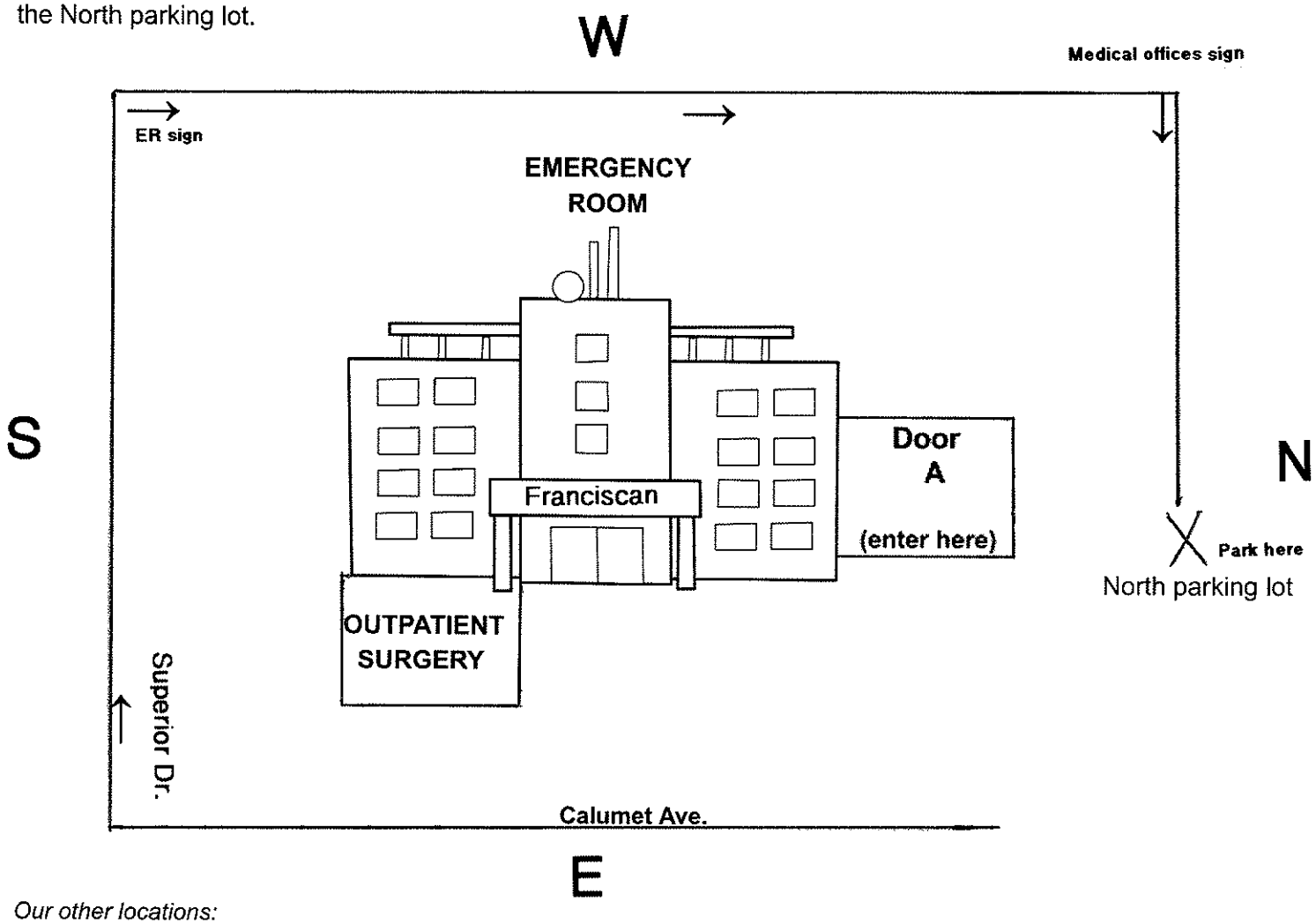
Medication	**Dosage**	**Frequency**

Consultants In Gastroenterology

Directions to our Muster location: 701 Superior Dr., Suite G., Munster, IN 46321 (located on the 2nd Floor of the Medical Offices inside Franciscan Hospital, Enter through **Door A**)

If coming from the North: Our office is 2.5 miles from Interstate 80/94 and Calumet Ave.
We are located just South of 45th St. Turn right at Superior Dr. and follow the signs to Medical offices around the back of the hospital to the North parking lot.

If coming from the South: Our office is 3.5 miles from Rt. 30 and Calumet Ave. We are located just North of Fitness Pointe. Turn left at Superior Dr. and follow the signs to Medical offices around the back of the hospital to the North parking lot.



Our other locations:

Dyer Marcotte Medical group - 16000 W. 101st Ave., Dyer, IN 46311 (Dr. Kniaz sees patient's here)

Hammond FPN clinic - 5500 Hohman Ave. Suite 2 A, Hammond, IN 46324 (located across the street from Franciscan Hospital and SW corner of Ogden St. & Hohman Ave.) Dr. Appannagari / Dr. Lodhi see patient's here.

Olympia Fields - 20121 Crawford Ave., Olympia Fields, IL 60641 (Located North of St. James Hospital)
Dr. Efrusy sees patient's here.

St. John - 9660 Wicker Ave(Rt. 41) St. John, IN 46373 (Located on the 2nd Floor of the Community Outpatient center)
Dr. Cahan / Dr. Herbstman see patient's here.

Whiting - 2075 Indianapolis Blvd. Whiting, IN 46394 (Located just North of 121st St. across the street from Little Caesars pizza) Dr. Nallapareddy sees patient's here.