Sanjay Chaudhry, M.D.
Board Certified in Gastroenterology & Hepatology

Digestive Disease Center
300 West Main Street
St. Clairsville, OH 43950

NAME:_____ AGE:_____

1. MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Heart disease	Crohn's	Irritable Bowel	Stroke	Lung disease_____
Heart attack	Colitis	Ulcers	Thyroid disease	Cancer_____
Heart murmur	Diverticulosis	Gallstones	Kidney disease	Chemo/radiation_____
High blood pressure	Polyps	Hiatal Hernia	Diabetes	Liver disease_____
High Cholesterol	Hemorroids	Anemia	Pancreatic disease	Sleep apnea

2. SURGICAL HISTORY:_____

_____

_____

3. SOCIAL HISTORY:

Smoking: Current:_____ Ex-smoker:_____ Amount:_____
Alcohol: Amount:_____ How long:_____
Recreational Drugs: What kind:_____ Received Blood Transfusions in past Y N
Any difficulty with anesthesia or sedation in past? Yes No (if yes, explain _____)
Any previous cardiac arrest or cardioversion? Yes No (if yes, explain _____)
Any difficulty with IV insertion? Yes No

4. FAMILY HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Colon cancer	Stomach cancer	Liver disease	Heart disease
Colon polyps	Pancreatic cancer	Diabetes	Lung disease
Ulcers	Esophageal cancer	High blood pressure	Other cancer

5. (FEMALES ONLY): Menstrual Irregularities: Y N LAST PERIOD:_____

6. PSYCHOLOGICAL DISTURBANCES: (Depression/High stress/Anxiety/Bipolar)_____

7. MEDICATION ALLERGIES:_____

8. CURRENT MEDICATIONS AND DOSAGE (INCLUDING OVER THE COUNTER):

_____

_____

_____

_____

9. CURRENT SYMPTOMS/PROBLEMS: (PLEASE CIRLCE ALL THAT APPLY)

Heartburn	Bloating/Gas	Decreased appetite	Seizures	Fever/chills/sweats	Cough/sore throat
Weight loss	Diarrhea	Abdominal pain	Headaches	Fatigue	Wheezing
Nausea/vomiting	Constipation	Jaundice	Tremors	Chest pain	Skin rash
Indigestion	Rectal bleeding	Bleeding tendency	Numbness	Skipped beats	Back pain
Difficulty swallowing	Black stools	Itching	Confusion	Leg swelling	Arthritis
Painful swallowing	Change in stool size	Cold/congestion	Dizziness	Short of breath	Urinary problems
Bitter taste	Rectal pain/itching	Incontinence			

10. RECENT LABS/X-RAYS:_____ **WHEN:**_____ **WHERE:**_____

11. IF YOU WOULD LIKE MORE INFORMATION ABOUT LIVING WILL/ADVANCE DIRECTIVES, INQUIRE AT FRONT DESK.

12. AS WE ARE CONSTANTLY STRIVING TO PROVIDE THE BEST PATIENT CARE POSSIBLE, ANY COMMENTS WOULD GREATLY BE APPRECIATED.

DIGESTIVE DISEASE CENTER: GENERAL INFORMATION & POLICY

NAME:_____SOCIAL SECURITY #:_____

BIRTHDATE:___/___/____ AGE: _____SEX:___ SPOUSE BIRTHDATE: ___/___/___

SPOUSE'S NAME: _____SPOUSE'S SOCIAL SECURITY#: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP: _____ _____

CELL#:_____WORK #: __ _____HOME **PHONE#:**_____

OCCUPATION:_____ EMPLOYER:_____

NEXT OF KIN: _____PHONE NUMBER:_____

PHARMACY: _____ LOCATION: _____

PRIMARY CARE PHYSICIAN/REFERRING MD_____

PLEASE PROVIDE US WITH INSURANCE CARDS TO COPY FOR CHART WITH APPLICABLE COPAYMENT

OUR CREDIT POLICY AND AUTHORIZATION:

1. I hereby give permission to this office to release pertinent medical information concerning me to my insurance company (as outlined by HIPPA regulations) to pay all proceeds for medical services rendered me or my dependents to S. Chaudhry, MD. Photogenic copy of this authorization shall be as valid as the original. I understand any balance due is my responsibility.

2.MEDICARE PATIENTS: I certify that the information given by me in applying for payment under title XVIII of the social security act is correct I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries. I request that payment of authorization benefits be made on my behalf. I assign the benefits be made on my behalf.

3. Assign the benefits payable to S Chaudhry, MD or authorize his office to submit a claim to Medicare for payment. I request that payment under the medical insurance services be made to S Chaudhry, MD on any bills for any medical services rendered to be by this office. A photogenic copy of this authorization shall be as valid as the original.

4.CANCELLATION POLICY: Failure to notify our staff of cancellation within 48 hours prior to your appointment will result in a charge to you: $25.00 for office and $50.00 for procedure cancellations

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT AND AGREE TO ABIDE BY THE POLICIES.

_____**Signature**

_____**Date**