New pat

KAILASH C SINGHVI MD
385 RT 18
WEST FERRIS PLAZA UNIT K
EAST BRUNSWICK, NJ,08816

Patient Information Form

Name: _____ Date: _____ Sex: _____

Address: _____ Date of Birth: _____ Age: _____

City/State: _____ Zip: _____ SS#: _____

Marital Status: ☐Married ☐Divorced ☐Widow(er) ☐Single E-Mail: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

GOVERNMENT MANDATED QUESTIONS *Please Answer ALL 3 Questions*

Ethnicity (circle 1): Hispanic / Non-Hispanic Preferred Language: _____

Race (circle 1): American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White Other

How did you hear about us? : ○*Website/Online* ○*Physician Referral* ○*Friend/Family Member* ○*Already a patient*

Pharmacy Name, Telephone #, & Address: _____

_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Patient's Employer/School: _____ Phone #: _____

Employer/School Address: _____

Primary Care Physician: _____ Address: _____ Phone #: _____

Referring Physician: _____ Address: _____ Phone #: _____

Primary Insurance

Policy Name: _____
Policy Holder: _____
Relationship to Policy Holder: _____
Date of Birth of Policy Holder: _____
Policy #: _____ Group #: _____

Secondary Insurance

Policy Name: _____
Policy Holder: _____
Relationship to Policy Holder: _____
Date of Birth of Policy Holder: _____
Policy #: _____ Group #: _____

- ✓ I hereby authorize payment of medical benefits billed to my insurance to Kailash Singhvi MDPC I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance.
- ✓ I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

_____
Signature of patient or guardian

_____
Date

Consent for Release of Information for Treatment, Payment, and Health Care Operations

I, _____, hereby authorize Kailash Singhvi MDPC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Kailash Singhvi MD can refuse to treat me.

I have been informed that Kailash Singhvi MD has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Kailash Singhvi MD, in writing, but if I revoke my consent, such revocation will not affect any actions that Kailash Singhvi MD took before receiving my revocation.

I understand that Kailash Singhvi MD has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request the Kailash Singhvi MD restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Kailash Singhvi MD does not have to agree to such restrictions, but that once such restrictions are agreed to, Kailash Singhvi MD must adhere to such restrictions.

_____

Printed Name of Patient or Patient's Representative

_____

Relationship to the Patient

_____ _____

Signature of Patient or Patient's Representative **Date**
(Form MUST be completed before signing)

COMPREHENSIVE GASTROINTESTINAL HEALTH
Health History Form

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

HEIGHT: _____ WEIGHT: _____ PRIMARY CARE DOCTOR: _____

PHARMACY (name, location, phone/fax number): _____

GENDER IDENTITY

☐ Female ☐ Male ☐ Non-binary ☐ Other ☐ Trans (male to female) ☐ Trans (female to male)

SEX ASSIGNED AT BIRTH

☐ Female ☐ Male ☐ Uncertain

ALLERGIES

☐ NONE ☐ Codeine ☐ Iodine dye ☐ Morphine ☐ Propofol ☐ Surgical tape
☐ Aspirin ☐ Demerol ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Versed

Other: _____

Any prior difficulties with sedation or anesthesia (nausea/vomiting, high tolerance, other)? ☐ Yes ☐ No

REASON FOR YOUR VISIT TO THE OFFICE

☐ Heartburn ☐ Difficulty swallowing ☐ Painful swallowing ☐ Regurgitation
☐ Excessive belching ☐ Chest pain ☐ Nausea ☐ Vomiting
☐ Upper abdominal pain ☐ Lower abdominal pain ☐ Bloating ☐ Gas/flatulence
☐ Diarrhea ☐ Constipation ☐ Narrowed stools ☐ Rectal pain/itch
☐ Rectal bleeding ☐ Black stools ☐ Hemoccult + stools ☐ Anemia
☐ Decreased appetite ☐ Weight loss ☐ Abnormal liver tests ☐ Jaundice
☐ Screening colonoscopy ☐ Personal history of colon polyps/cancer ☐ Family history of colon polyps/cancer ☐ Abnormal ultrasound or CAT scan

Other: _____

Have you had any of the following done to evaluate for the cause of your symptoms?

☐ Laboratory tests or blood work
☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies)
☐ Endoscopies (upper GI scope/EGD, ERCP, colonoscopy)
☐ Emergency room visits

** *If possible, we would greatly appreciate it if you could please bring any of these relevant records with you or have them faxed to our office in advance of your visit 224.407.2255.*

What medications, supplements, or dietary interventions have you tried to treat your symptoms with (non-prescription and prescription)?

_____

_____

Kailash Singhvi MD PC
385 RT 18 WEST FERRIS PLAZA STE K
EAST BRUNSWICK, NJ, 08816
P: (732) 238-4343 FAX: (732) 238-6981

NO SHOW/ NO CALL AND CANCELLATION FEE

As we strive to efficiently run our growing small office, we are finding it increasingly difficult to keep patients booked accordingly. To keep all patients happy, we are now implementing a NEW POLICY for all patients (new and existing). There will now be a charge of $50 dollars to all patients who No Call/ No Show and a fee of $25 dollars for patients who cancel their appointment after the 24-hour window. This will be for all types of appointments such as but not limited to procedures and consultations. Our office will continue to make our 3-round calls to confirm all appointments within a 3–5-day period. It is your patient responsibility to contact our office for any changes to your appointment even after booked in person/online/over the phone. It is your patient's responsibility to notify the office of any phone number changes, so our office can continue to contact to confirm/cancel/ reschedule. If you cannot reach the office, please leave a voicemail message. All charges will be mailed out or taken the day of missed appointment through the cc information given.

I, _____, accept all charges and authorize the office of Kailash Singhvi MD P.C to collect a payment of $50 for a No Call/ No Show missed appointment or a $25 fee for an appointment cancelled after the 24-hour grace period. I understand the policy allows me to make any changes 24 hours before my appointment. I understand even if I booked and confirmed in office/over phone, I must still notify the office for any changes. I understand I must contact the office for any changes to my contact information. I understand that even if I have an appointment booked, I must still confirm the booked appointment to secure my place and avoid a fee beforehand. I understand the charge will be automatically taken the day of, to where I have given my information, or sent out to me by mail. I understand if mailed out to me, I must contact the office or mail a check to pay invoice. I understand if I miss 3 consecutive appointments through this policy the office has a right to no longer book any future appointments.

CC: _____ Exp: _____

CVV: _____ Name of cardholder: _____

Signature: _____ Date: _____

***Signature is required by all patients as acknowledgment of our policy, but CC information is not. This page will be stored in your chart and will remain there until no longer a patient in our office.