Vasantha Pai, MD PC
2810 Frank Scott Parkway West, Suite 716, Belleville IL 62223
Phone: 618-355-0880 Fax: 888-339-3810

Patient Information

Name:_____ DOB:_____ Email Address:_____
Phone #_____Secondary Phone #_____
Sex: M___F___ Marital Status:_____
Address:_____
Primary Care Physician:_____
Reason for visit:_____
HIPAA (more information on back of sheet). Please provide us with the names of individuals whom we can contact regarding your care/share information with concerning your healthcare or treatment received:
Name:_____Phone #_____ Relationship to patient:_____
Name:_____Phone #_____ Relationship to patient:_____
Name:_____Phone #_____ Relationship to patient:_____

We may need to contact you regarding your healthcare or to remind you of upcoming appointments. To protect your privacy, please indicate which methods of communication are acceptable for us to use when trying to contact you. In the event we are unable to contact you, we will leave a message for you.
Home or mobile phone_____ Email_____

Past Medical History: Do you have a history of: (Circle all that apply)
Pacemaker Artificial heart valve Defibrillator Stroke Diabetes Colon Cancer
Gastrointestinal disorders High blood pressure Heart disease

Family/Social History: Does anyone in your family have (circle all that apply):
Colon Cancer Crohn's disease Ulcerative Colitis

Do you smoke cigarettes?____Yes ___No. If yes, how many packs per day?___ For how many years?_____
Do you drink alcohol?_____Yes _____No. If yes, how often?_____

Have you ever had an EGD?____Yes or no. If yes, when?_____
Have you ever had a Colonoscopy?_____Yes or no. If yes when?_____
Past Surgical History:
_____

Allergies:_____

DOCUMENT IS TWO-SIDED. PLEASE TURN OVER AND SIGN. THANK YOU!

I hereby assign directly, to Vasantha Pai, MD, all medical benefits, if any, otherwise payable to me for services rendered. I understand that all services rendered to me (or my dependents) are charged directly to me and I am personally responsible for payment of all charges whether paid or not paid by insurance. The patient or their responsible legal guardian agrees to pay any and all costs of collection and/or attorney fees required to settle an account balance. I authorize the release of all information necessary to my current or valid insurance carrier in order to secure the payment of benefits for services rendered.

It is my responsibility, the patient, to know the coverage and requirements of my health insurance plan regarding diagnostic testing, procedures, physician referrals, and other services. I will be sure I have obtained the necessary referral from my primary care physician before my appointment or I will be asked to reschedule. If I can not provide current insurance information I will be required to pay in full for that day's visit. I understand a payment plan may be implemented at the discretion of the office dependent on my past payment history. I understand it is also my responsibility to notify the office 24 hours prior to my appointment of any cancellations, as I may be subject to a $25 late cancellation or missed appointment fee. I also understand I must notify the office with any changes of address, phone numbers, or insurance.

The HIPAA Privacy Rules require us, Dr. Vasantha Pai, MD PC, to protect the privacy of the patient's health information. We are unable to discuss or share relevant information about the patient or the patient's healthcare with others without the patient's permission. We understand every patient and family is different and we can not make assumptions on who may be involved in the patient's care or payment for the patient's care. On the front side of the form, please provide us with the name(s) of family members or other individuals whom we can share information with concerning the patient's healthcare or treatment received.

The Notice of Privacy Practices provides detailed information about how we may use or disclose the patient's confidential information. By signing this form, you, the patient, acknowledge receipt of Dr. Vasantha Pai's Notice of Privacy Practice.

Patient Name:_____
Patient Signature:_____
Signature of Individual Signing for patient (if applicable):_____
Relationship of Individual above to patient (if applicable):_____
Date:_____