Deepak Khurana, M.D.
Board Certified in Gastroenterology

Specialists in Gastroenterology

Thank you for choosing our practice, and we look forward to taking part in your medical care. Enclosed you will find our New Patient Paperwork. Please feel free to fill these forms out prior to your office visit. If you'd rather, you may fill them out once you arrive at our office, however we do ask that you arrive early and allow 30 minutes to complete them. If you have any questions, please call us at 847-931-7550

Please remember to bring the following to your office visit:

- Photo ID
- Insurance Card
- Current Medication List
- Pharmacy Name & Phone Number
- Referral (if needed)
- Co-Payment

Your appointment location:

☐ **Elgin Office:** 1710 N. Randall Road
Suite# 280
Elgin, IL 60123

☐ **Fox River Grove Office:** 912 W. Northwest Hwy
Suite# 100
Fox Rover Grove, IL 60021

Your appointment Date:_____ Time:_____

Thank you!

1710 N. Randall Road · Suite #280 · Elgin, IL 60123
912 Northwest Highway · Suite 100 · Fox River Grove, IL 60021
Phone: 847-931-7550
www.specgastro.com

DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ____/____/____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

☐ OTHER _____

EMPLOYER _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE (_____) _____

WORK PHONE (_____) _____

CELL PHONE (_____) _____

PREFERRED CONTACT # ☐ HOME ☐ WORK ☐ CELL

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US? _____

HEALTHCARE REFORM QUESTIONS

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

RACE:

_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian
_____ Black or African
_____ White
_____ Hispanic
_____ Other Race _____

ETHNICITY:

_____ Hispanic
_____ Non-Hispanic
_____ Unreported/Refused to Report

LANGUAGE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

INSURANCE COMPANY _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY # _____ GROUP # _____ PHONE (_____) _____

GUARANTOR

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH ____/____/____

RELATIONSHIP _____ DAYTIME PHONE (_____) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNATURE DATE

Specialist in Gastroenterology
Financial Policy

Specialists in Gastroenterology **believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.**

1. **PAYMENT** – is expected at the time of your visit. We will accept cash, credit card, or check. Payment will include any unmet deducible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. For procedures, we require payment via cash or credit card. We do ask for copy of an ID or license due to cases of identity theft. Please ask about our fees before the visit.

2. **INSURANCE** – We are participating providers with several insurance plans. We will file all insurance claims. Please remember insurance is contracted between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for your care are due at the time of services. Due to the existence of multiple different insurance products, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefit department about services and physicians before your appointment. You are responsible for payment if your claim is rejected by insurance.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the total charges. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **BALANCES** – Older than 90 days without a payment will be turned over to a Collection Agency.

4. **RETURNED CHECKS** – Will incur a $25.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus service charges.

5. **ACCOUNT PRINCIPLES** – Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of services.

6. **COMPLETING INSURANCE FORMS, COPYING MEDICAL RECORDS, ETC** –We may require pre-payment for completing forms, copying medical records, or for extra transcription by the doctors. The charges are determined by the length and complexity of the task, form or letter.

7. **CANCELLATION FEES**- If you fail to show for an office visit appointment, or fail to cancel at least 24 hours in advance, you will be charged a $75.00 fee. If you fail to cancel a procedure 5 business days in advance, or fail to show on your procedure date, you will be charged a $200.00 fee.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or Responsible Party, if minor) **Date**

_____

Print Name of Patient

Name:_____ Date of Birth:_____

Date:_____ Height:_____ Weight:_____ Primary Care Doctor:_____

Any ALLERGIES to medications? _____ Dr. Khurana Signature:_____

Yearly Patient History Form

Cardiovascular & Blood Disorder History:

HYPERTENSION (HIGH BP)?	Y/N
HYPOTENSION (LOW BP)?	Y/N
HEART DISEASE/FAILURE?	Y/N
If yes, artificial valve?	Y/N
If yes, stent?	Y/N
If yes, pacemaker?	Y/N
If yes, defibrillator/AICD?	Y/N
If yes, heart attack history?	Y/N
-If yes, year of heart attack:	
IRREGULAR HEART BEAT?	Y/N
HEART PALPITATIONS?	Y/N
SWELLING/EDEMA (feet/ankles)?	Y/N
BLOOD CLOT HISTORY?	Y/N
THROMBOCYTOPENIA (low platelet count)?	Y/N
EASY BLEEDING/BRUISING?	Y/N
ANEMIA?	Y/N
PREVIOUS BLOOD/PLATELET TRANSFUSION?	Y/N
-If yes, when & where?	
Notes:	

Pulmonary History:

ASTHMA?	Y/N
COPD?	Y/N
EMPHYSEMA?	Y/N
SHORTNESS OF BREATH?	Y/N
WHEEZING?	Y/N
FREQUENT COUGH?	Y/N
SLEEP APENA?	Y/N
If yes, CPAP or BiPAP use?	CPAP or Bi PAP

GASTROINTESTINAL SURGERY	DATE COMPLETED:

Please fill in if procedures were done with a different practice so we can retrieve records.

HISTORY	COLONOSCOPY	UPPER ENDOSCOPY
DATE:		
LOCATION:		
DOCTOR:		
RESULTS:		

DO YOU...	
CURRENTLY SMOKE?	Y/N-
HISTORY OF SMOKING?	Y/N-
DRINK ALCOHOL?	Y/N-
CONSUME CAFFEINE?	Y/N-
HISTORY SUBSTANCE ABUSE? If yes, describe.	Y/N-

Additional Questions:

REACTION TO ANESTHESIA?	YES or NO
If yes, when?	
FAMILY HISTORY OF ANESTHESIA REACTION?	YES or NO
If yes, relationship to you.	
IMPLANTS/PROSTHETICS?	YES or NO
If yes, what and where?	
Breast cancer/lymph node removal? Which breast/side?	Y or N Left, Right, or Both
Any recent abnormal labs?	YES or NO
If yes, what lab/test?	
If yes, what facility (name)?	

NON-GI SURGERIES:	DATE:

Name:_____ Date of Birth:_____

Endocrine, Neuromuscular, Neuro History:

DIABETES HISTORY?	Y/N
If yes, oral meds?	Y/N
If yes, insulin?	Y/N
EXCESSIVE THIRST?	Y/N
TEMPERATURE INTOLERANCE?	Y/N
THYROID DISEASE?	Y/N
ARTHRITIS?	Y/N
HIP FRACTURE/JOINT REPLACED?	Y/N
If yes, when & where?	
MUSCLE WEAKNESS?	Y/N
HEADACHES?	Y/N
HISTORY OF STROKE?	Y/N
If yes, date & type?	
HISTORY OF SEIZURES?	Y/N
DIZZINESS?	Y/N
VERTIGO?	Y/N

Psychiatric, GU, Skin, General History:

KIDNEY DISEASE (stage)?	Y/N
If yes, on dialysis?	Y/N
KIDNEY STONES?	Y/N
FREQUENT URINATION?	Y/N
PAINFUL URINATION?	Y/N
ANXIETY?	Y/N
DEPRESSION?	Y/N
NERVOUSNESS?	Y/N
RASH OR ITCHING?	Y/N
If yes, location & duration?	
CHANGE IN SKIN COLOR?	Y/N
PROBLEMS SWALLOWING?	Y/N
RECENT WEIGHT CHANGE?	Y/N
FATIGUE?	Y/N
NOTES:	

GI History/Cancer (circle any that apply):

Abdominal pain	Constipation	Diarrhea
Nausea	Vomiting	Change in bowels
Colon polyps	Diverticulosis	Diverticulitis
Celiac disease	Crohn's disease	Ulcerative colitis
Hemorrhoids	Blood in stool	Rectal bleeding
Tarry stools	Hiatal hernia	GI ulcers
Varices	Barrett's Esophagus	Reflux/heartburn
Cirrhosis-liver	Hepatitis	Jaundice
Pancreatic disease	Pancreatic cancer	Colon cancer
Prostate cancer	Ovarian cancer	Uterine cancer
Loss of appetite	Gallbladder disease	Gallstones

Please list/explain any ADDITIONAL medical history that we should be made aware of:

_____

_____

_____

Reason for visiting a gastroenterology practice:

_____

_____

_____

REQUEST FOR CONFIDENTIAL COMMUNICATION

I request that all communications to me (by telephone, mail or otherwise) by *Specialists in Gastroenterology* and/or its staff be handled in the following manner:

For written communication, address to:

Patient Name:_____ Date of Birth:_____
(Please Print)

Patient Address:_____

City, State, Zip:_____

For other communication:

Home #:_____

Work #:_____

Cell#:_____

EMAIL: _____

Pharmacy Name: _____ **Pharmacy Number:** _____

_____ _____
Primary Insurance Name **Policy Holder Name / Date of Birth**

_____ _____
Secondary Insurance Name **Policy Holder Name / Date of Birth**

Primary Care Doctor:_____ **Office Phone:**_____

Should the need arise; whom may we speak to regarding your medical information and care? (Example: parents, wife, husband, adult children, etc...)

Name:_____ Relationship:_____

Home#:_____ Cell#:_____

Work #:_____

I understand that this above authorization, to speak with the above-mentioned person, will be valid until such time as written correspondence regarding a change is received in our office, or a new form is submitted.

Patient Signature:_____ **Date:**_____

Specialists in Gastroenterology

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I,_____, hereby authorize Specialists in Gastroenterology 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, Specialists in Gastroenterology can refuse to treat me.

I have received a copy of the Notice of Privacy Standards ("Notice"), which more fully describe the uses, and disclosure that can be made of my individually identifiable health information for treatment, payment and health care operations.

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

I understand that Specialists in Gastroenterology has reserved the right to change his/her privacy practices and that I can obtain such changes notice upon request.

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

_____ _____

Signature of patient (or patient's representative) **Date**
(Form MUST be completed before signing)

_____

Print name of patient or patient's representative

_____

Relationship to the patient