GI ASSOCIATES OF DELAWARE
NAT RAMANI, M.D.

742 S. Governors Avenue, Suite 3 Dover, DE 19904
Phone: 302-678-5008 | Fax: 302-678-5505

Name: _____
Last **First** **Middle**

Birth date:_____/_____/_____ **Family Doctor**: _____
mm dd yy

ALLERGIES: _____

_____

MEDICATIONS (Name, dosage, and how often you take it)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Circle Yes or No for all Questions below (Symptoms you are currently having or have had in the last 3 months)

GI		General		Ears, Nose, Throat		Respiratory	
Abdominal pain	Yes No	Fever	Yes No	Ear pain	Yes No	Shortness of breath	Yes No
Nausea	Yes No	Chills	Yes No	Hearing problem	Yes No	Cough	Yes No
Vomiting	Yes No	Night sweats	Yes No	Nasal congestion	Yes No	Wheezing	Yes No
Gas	Yes No	Fatigue	Yes No	Nasal discharge	Yes No	**Genitourinary**	
Bloating	Yes No	Weight loss (unintentional)	Yes No	Hoarseness of voice	Yes No	Difficult urination	Yes No
Heartburn	Yes No	Poor appetite	Yes No	Recurrent sore throat	Yes No	Blood in urine	Yes No
Diarrhea	Yes No	**Eyes**		**Cardiac**		Frequency in urination	Yes No
Constipation	Yes No	Blurred vision	Yes No	Chest pain	Yes No	Nighttime urination	Yes No
Black stools	Yes No	Eye drainage	Yes No	Leg swelling	Yes No	Urinary incontinence	Yes No
Blood in stool	Yes No	Eye pain	Yes No	Palpitations	Yes No	**Skin**	
Difficulty Swallowing	Yes No	**Neurologic**		Recent heart attack	Yes No	Skin rash	Yes No
Painful swallowing	Yes No	Dizziness / Fainting / Both	Yes No	**Hematologic / Lymphatic**		Jaundice	Yes No
Musculoskeletal		Headaches	Yes No	Easy bruising	Yes No	Itching / Dry Skin / Both	Yes No
Joint pain	Yes No	Seizures	Yes No	Anemia	Yes No	**Endocrine**	
Back pain	Yes No	Weakness	Yes No	Excessive bleeding	Yes No	Heat or Cold intolerance	Yes No
Muscle aches	Yes No	History of falls	Yes No	Swollen lymph nodes	Yes No	Excessive thirst or hunger	Yes No

Past Medical History		**Past Surgical History**		**Family History**	
Colon polyps	Yes No	Appendectomy	Yes No	Colon cancer	Yes No
Acid Reflux Disease (GERD)	Yes No	C-section	Yes No	Heart disease	Yes No
History of stomach ulcers	Yes No	Gallbladder surgery	Yes No	High blood pressure	Yes No
High blood pressure	Yes No	Hysterectomy	Yes No	Diabetes	Yes No
High cholesterol	Yes No	Cardiac Bypass	Yes No	Asthma	Yes No
Heart disease **Specify Type:**_____	Yes No	Joint replacement **Which Joint:** _____	Yes No	Arthritis	Yes No
Asthma / COPD / BOTH **Circle one applicable**	Yes No	Valve replacement **Which Valve:** _____	Yes No	Ulcers	Yes No
Sleep apnea	Yes No	Hernia repair	Yes No	Gall stones	Yes No
Diabetes	Yes No	Upper GI Endoscopy	Yes No	Skin cancer	Yes No
Anxiety / Depression / BOTH **Circle one applicable**	Yes No	Colonoscopy	Yes No	Cervical cancer	Yes No
Arthritis	Yes No	Sigmoidoscopy	Yes No	Breast cancer	Yes No
Thyroid problem	Yes No	Cardiac catheterization	Yes No	Ovarian cancer	Yes No
LIST ANY OTHER MEDICAL CONDITIONS		**LIST ANY OTHER SURGERIES**		Prostate cancer	Yes No

Marital Status

S ☐ **M** ☐ **W** ☐ **D** ☐ **Sep** ☐

Smoking **Yes No**

How many cigarettes daily?

_____

Alcohol Use **Yes No**

How often?

_____

Drug use **Yes No**

_____

Patient's Signature

_____

Date

Natwarlal V. Ramani, M.D.
Phone: 302-678-5008 | Fax: 302-678-5505

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742 S. Governors Avenue, Ste 3, Dover, DE 19904

Patient's Name: _____,_____ **Sex**: **M / F**
Last Name **First Name** **Middle**

_____ **Marital Status**: S☐ M☐ W☐ D☐ Sep☐ **Birth Date**: _____/_____/_____ **Race**:_____
Social Security Number

Address: _____
Street **City** **State** **Zip**

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

Email: _____ **Referred by**: _____ **Family Dr.**: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy #**: _____

Secondary Insurance: _____ **Policy #**: _____

Medication Insurance: _____ **Policy #**: _____

Insured Person (If other than patient)

Name: _____ _____
Last Name **First Name** **Middle** **Social Security Number**

Date of Birth: _____/_____/_____ **Relationship**: _____ **Phone #**: _____
Month **Date** **Year**

EMERGENCY CONTACT

Spouse Name: _____ **Home #:**_____ **Work #:** _____ **Cell #:** _____

Emergency Contact: _____ **Phone #**: _____ **Relation**: _____
(If other than spouse) **(If possible, provide phone # different than yours)**

PHARMACY INFORMATION

Pharmacy Name: _____ **Location:** _____ **Phone #:** _____

EMPLOYMENT INFORMATION

Employer Name: _____ **Phone #**: _____

Address: _____ **Occupation**: _____

AUTHORIZATION / PROMISSORY NOTE

I authorize my doctor to bill my insurances for all services rendered and release any required information.
I promise to pay any co-pay, deductible, coinsurance, or any patient liability not covered by insurance.
I authorize payment of the medical benefits directly to the doctor for services rendered.
I understand that I will be responsible for paying a $15 late fee if turned over to a collection agency and a 40% collection fee and any legal fees if sent to National Collection Bureaus for collection of any debt.
I understand I will be discharged from this practice as a patient if I miss three consecutive appointments.

Patient/Guarantor Signature: _____ **Date**: _____/_____/_____
Month **Date** **Year**

HIPAA – I acknowledge that I have been provided the office's Notice of Privacy Practices.

I AUTHORIZE _____**, Birth Date:** _____**, Relationship:** _____ **to discuss and receive my health information. This authorization will be valid until revoked by me in writing.**

Patient/Guarantor Signature: _____ **Date**: _____/_____/_____
Month **Date** **Year**