SANJAY T. BHAT, M.D.
Board-certified Gastroenterologist
314-729-1717
BHATGI.COM

Please fill out these forms (all pages are double sided) and bring with you to your procedure. Please give to the nurse assisting you and ask that they be given to Dr. Bhat. Thank you.

Patient Registration Form

Date:________________________________

Primary Care Physician: ____

Referring Physician: ____

Other doctors that you see: ____

Briefly Describe Your Present Symptoms: ____

____

When symptoms began (approximate): _______________________

Patient Information: (PLEASE PRINT)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_______________________(First)_______________(MI)______Previous Name ________________________

EMAIL: ____

Address Line 1 ____

Address Line 2 ____

City, State ____ ZIP ___________________________

Home Phone______________________ Cell # ______________________ Work Phone__________________Ext. ___________

Date of Birth MM____/DD_____ /YYYY______ Age_____ Sex: Female ☐ Male ☐ Trasgender ☐

Marital Status (circle one) Married Single Divorced Widowed

Social Security Number ________ - ______ - __________ Employer Name ______________________________________

Employer Address____

City_____________________________ZIP____________ Employer Phone Number________________________________

Employment Status (circle one) Full-Time Part-Time Not Employed Self-Employed Retired Active Military

Emergency Contact __________________________________ Phone Number _____________________________

Pharmacy Name ____ Pharmacy Zip Code:______________________

Pharmacy Phone Number ____

Sanjay T. Bhat, M.D.
Patient History

REVIEW OF SYSTEMS:

Do you have or have you ever had any of the following: **(PLEASE CIRCLE YOUR ANSWER)**

Constitutional			**Respiratory**		
Recent Weight Gain?	Yes	No	Hoarseness	Yes	No
If yes, how much?			Wheezing/History of Asthma	Yes	No
Recent Weight Loss?	Yes	No	Shortness of breath	Yes	No
If yes, how much?			Cough	Yes	No
Fatigue	Yes	No	**Genitourinary**		
Weakness	Yes	No	Frequent Urination	Yes	No
Fever	Yes	No	Burning or painful urination	Yes	No
Eyes			Blood in urine	Yes	No
Wear glasses or contacts?	Yes	No	Kidney Stones	Yes	No
Double or blurred vision	Yes	No	**Musculoskeletal**	Yes	No
Glaucoma	Yes	No	Joint pain	Yes	No
Ear, Nose, and Throat			Muscle pain or cramp	Yes	No
Hearing Loss	Yes	No	Joint stiffness or swelling	Yes	No
Sinus Problems	Yes	No	Weakness of muscles/joints	Yes	No
Cardiovascular			**Skin**		
Chest Pain	Yes	No	Rash or itching	Yes	No
Irregular heartbeat	Yes	No	Easy bruising	Yes	No
High Blood Pressure	Yes	No	Change in hair or nails	Yes	No
Swelling of hands, feet, ankles	Yes	No	**Neurological**		
Heart Murmurs	Yes	No	Frequent headaches	Yes	No
Palpitations	Yes	No	Lightheaded or dizziness	Yes	No
Gastrointestinal			Seizures or convulsions	Yes	No
Difficulty swallowing	Yes	No	Stroke	Yes	No
Loss of appetite	Yes	No	Fainting	Yes	No
Vomiting	Yes	No	**Psychiatric**		
Vomiting blood	Yes	No	Anxiety	Yes	No
Pancreas Problems	Yes	No	Depression	Yes	No
Abnormal Tests	Yes	No	Sleep problems	Yes	No
Abdominal pain/bloating	Yes	No	**Endocrine**		
Nausea	Yes	No	Thyroid Disease	Yes	No
Liver Problems	Yes	No	Diabetes	Yes	No
Constipation	Yes	No	Excessive Thirst	Yes	No
Diarrhea	Yes	No	**Hematologic/Lymphatic**		
Blood in stool	Yes	No	Swollen Glands	Yes	No
Heartburn	Yes	No	Anemia	Yes	No
Hemorrhoids	Yes	No	Transfusion (If yes, when ________________)	Yes	No
			Phlebitis	Yes	No

Sanjay T. Bhat, M.D.
Patient History (cont)

SOCIAL HISTORY:

Marital Status (circle one): Single Married Separated Divorced Widowed

Do you currently use tobacco products? (circle one): Yes No

If yes, quantity per day: Cigarettes ______ Cigars _____ Chewing Tobacco _____

Started Age/Year: __________________ Stopped Age/Year ________________

Have you ever used illicit drugs? (circle one): Yes No

Are you currently using illicit drugs? (circle one): Yes No

Do you currently drink alcohol? (circle one): Yes No

Number per week: Beer _________ Wine _________ Distilled Spirits ________

Do you exercise regularly? (circle one) Yes No

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Medical History/Cancer	Age	Cause of Death/Any Cancers (What Kind?)
Father				
Mother				
Sibling				
Sibling				
Sibling				

Sanjay T. Bhat, M.D.
Patient History (cont)

PAST MEDICAL HISTORY:
Please check if you now have or have ever had any of the following:

☐ Cancer (if yes, what kind?)	☐ Heart Disease	☐ Defibrillator	☐ Goiter
☐ Leukemia	☐ Pacemaker	☐ Pneumonia	☐ Emphysema
☐ Stomach Ulcers	☐ Jaundice	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Tuberculosis	☐ Psoriasis	☐ Kidney Disease	☐ Colitis
☐ COPD/Emphysema	☐ Arthritis	☐ Stroke	

SURGICAL HISTORY:
Please list all surgeries and when the surgery was performed:

____

____

____

X-RAYS:
Have you ever had any of the following?

1. Upper GI Series Yes ______ No ______
2. Barium Enema Yes ______ No ______
3. Gall Bladder X-Ray Yes ______ No ______
4. CT Scan of abdomen Yes ______ No ______

Sanjay T. Bhat, M.D.
Patient History (cont)

MEDICATIONS:

Drug Allergies: ____

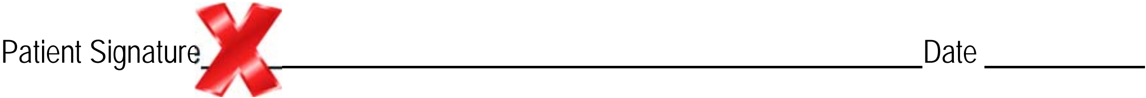
____

____

Are you allergic to **LATEX**? Yes No

Current Medications
Please list all medications you are currently taking including over-the-counter and herbal medications.

Medication	Dosage	Frequency


Patient Signature____Date __________

Sanjay T. Bhat, M.D.

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

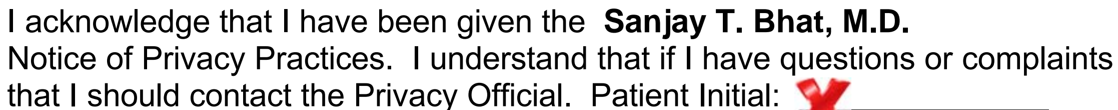
I understand that **Sanjay T. Bhat, M.D.** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Sanjay T. Bhat, M.D.** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Sanjay T. Bhat, M.D.**.

I acknowledge that I have been given the **Sanjay T. Bhat, M.D.** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: ____________



I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ________________

Patient (or Responsible Party) Signature ***Date***

Sanjay T. Bhat, M.D.
Consent Form

May Dr. Sanjay T. Bhat and/or members of the office staff release medical information to specified persons other than you? ☐ Yes ☐ No

If yes, please specify to whom this information may be released:

Authorized Person	Relationship to You
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

What information may be released?

Lab Results	Yes_____	No_____
X-Ray Reports	Yes_____	No_____
Medications	Yes_____	No_____
Appointments	Yes_____	No_____
Financial/Billing	Yes_____	No_____

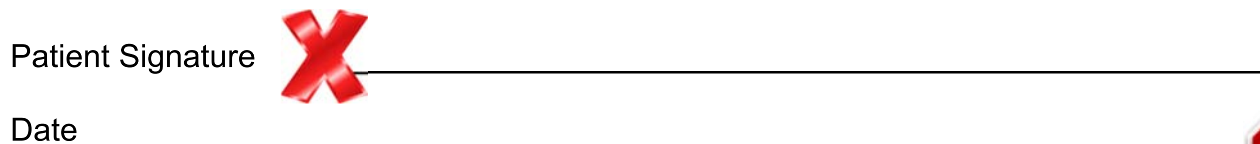
I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change his policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.



Patient Signature ____

Date ____