DR. GANESH DESHMUKH, MD & DR. ADEWUNMI ADEYEMO, MD

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

HEIGHT _____ WEIGHT _____ LAST BLOOD PRESSURE _____ OR UNKNOWN (circle if unknown)

REASON FOR VISIT _____

DURATION OF PROBLEM (CIRCLE) _____ DAYS WEEKS MONTH YEARS

SEVERITY (CIRCLE) MILD MODERATE SEVERE

ARE YOU CURRENTLY TAKING (CIRCLE) ASPIRIN COUMADIN PLAVIX NONE

PLEASE LIST CURRENT MEDICATIONS

_____

_____

PLEASE LIST DRUG ALLERGIES: _____

LATEX ALLERGY? (CIRCLE) **YES** **NO**

DIET FIBER INTAKE? (CIRCLE) **LOW** **MODERATE** **HIGH**

ANORECTAL PROBLEMS (CIRCLE) **YES** **NO**
BRIGHT RED RECTAL BLEEDING BURNING AFTER BM MUCOUS PROTRUSION ITCHING
GUIAC POSITIVE STOOL

CAN YOU HOLD YOUR BOWEL MOVEMENTS? (CIRCLE) **YES** **NO**
IF NOT, IS YOUR LOSS OF CONTROL: SOLID LIQUIDS FLATUS

ABDOMINAL PROBLEMS? (CIRCLE) **YES** **NO**
NAUSEA VOMITTING DIARRHEA CONSTIPATION BLOATING PAIN
IF PAIN, WHAT LOCATION? LOWER ABDOMEN UPPER ABDOMEN RIGHT SIDE LEFT SIDE

NEUROLOGICAL ILLNESS? (CIRCLE) **YES** **NO**
DIZZINESS WEAKNESS
IF DIZZINESS OR WEAKNESS, WHAT LOCATION? FACE TRUNK EXTEMITIES

CARDIOVASCULAR ILLNESS? (CIRCLE) **YES** **NO**
CHEST PAIN SHORTNESS OF BREATH DIFFICULTY BREATHING ON EXERTION

RESPIRATORY ILLNESS? (CIRCLE) **YES** **NO**
COUGH HEMOPTYSIS ASTHMA ATTACKS

URINARY SYMPTOMS? (CIRLE) **YES** **NO**
PYURIA (PUS IN URINE) HEMATURIA (BLOOD IN URINE) BURNING WHILE URINATING

DO YOU HAVE LIVER DISEASE? (CIRCLE) **YES** **NO**
JAUNDICE ITCHING BILARY COLIC FEVER BLEEDING DISORDER

DO YOU HAVE MUSCULOSKELETAL PROBLEMS? (CIRCLE) **YES** **NO**
JOINT PAIN SWELLING/NODELS(LUMPS) LEG PAIN DIFFICULTY WALKING

MEDICAL HISTORY - HAVE YOU OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

ANEMIA YES/NO
COPD YES/NO
STROKE YES/NO
GERD YES/NO
COLITIS YES/NO
DEFIBRILLATOR? YES/NO
HIGH BLOOD PRESSURE YES/NO
KIDNEY DISEASE YES/NO
PACEMAKER? YES/NO
CANCER YES/NO **TYPE?** _____
COLON POLYPS YES/NO
CHRONIC RENAL INSUFFCIENCY YES/NO
CORONARY ARTERY DISEASE YES/NO
OSTEOPOROSIS YES/NO
DIABETES MELLITUS YES/NO **TYPE?**_____
HEART PROBLEMS YES/NO
CROHN'S DISEASE YES/NO
OTHER:

SURGICAL HISTORY - HAVE YOU OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

ANGIOPLASTY YES/NO
C – SECTION YES/NO
HERNIA REPAIR YES/NO
COLECTOMY YES/NO
OTHER:
APPENDECTOMY YES/NO
CHOLECYSTECTOMY YES/NO
TUBAL LIGATION YES/NO
HYSTERECTOMY YES/NO

HEALTH MAINTENCE – PLEASE FILL IN DATE OF THE LAST PROCEDURE/EXAM, IF KNOWN

COLONOSCOPY/SIGMOIDOSCOPY? YES/NO DATE? _____

STOOL OCCULT CARDS? YES/NO DATE? _____

FAMILY HISTORY – PLEASE CIRCLE IF THE FOLLOWING MEMBERS OF YOUR FAMILY HAVE THE FOLLOWING

BREAST CANCER
MOM DAD SISTER BROTHER MATERNALAUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PATERNAL AUNT/UNCLE/GRANDMOTHER/GRANDFATHER
COLON CANCER
MOM DAD SISTER BROTHER MATERNALAUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PATERNAL AUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PROSTATE CANCER
MOM DAD SISTER BROTHER MATERNALAUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PATERNAL AUNT/UNCLE/GRANDMOTHER/GRANDFATHER
OVARIAN CANCER
MOM DAD SISTER BROTHER MATERNALAUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PATERNAL AUNT/UNCLE/GRANDMOTHER/GRANDFATHER
OTHER CANCER – TYPE? _____
MOM DAD SISTER BROTHER MATERNALAUNT/UNCLE/GRANDMOTHER/GRANDFATHER
PATERNAL AUNT/UNCLE/GRANDMOTHER/GRANDFATHER

SOCIAL HISTORY - HAVE YOU OR DO YOU CURRENTLY DO ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

DO YOU CURRENTLY SMOKE? YES/NO **FORMER SMOKER?** YES/NO

DO YOU USE RECREATION DRUGS? YES/NO **IF YES, PLEASE LIST** _____

DO YOU DRINK ALCOHOL? YES/NO

DO YOU EXERCISE REGULARLY? YES/NO

ARE YOU SEXUALLY ACTIVE? YES/NO **IS YOUR PARTNER:** MALE/FEMALE

I have answered the above pages to the best of my knowledge and have read the patient HIPAA and Privacy Consent Form, the Office Financial Policy and consent to the Agreement to Bill Insurance:

Patient Signature: _____ **DATE**_____

DR. GANESH DESHMUKH, MD & DR. ADEWUNMI ADEYEMO, MD

NAME(as it appears on drivers license) _____

GENDER: MALE FEMALE **(PLEASE CIRCLE)** **DATE OF BIRTH** _____

ADDRESS_____ **PHONE NUMBER** _____

CITY_____ **EMAIL ADDRESS** _____

STATE_____ **ZIP CODE** _____ **SOCIAL SECURITY #** _____

MARITAL STATUS: DIVORCED / LEGALLY SEPARATED / MARRIED / SEPARATED / SINGLE / WIDOWED **(CIRCLE)**

PHARMACY NAME AND PHONE NUMBER _____

REFERRING DOCTOR (FIRST & LAST NAME) _____**PHONE** _____

PRIMARY CARE DOCTOR (FIRST & LAST NAME) _____**PHONE** _____

EMERGENCY CONTACT NAME _____**PHONE** _____

RACE: WHITE, BLACK, ASIAN, HISPANIC/LATINO, MIDDLE EASTERN, NATIVE HAWAIIAN/PACIFIC, OTHER **(PLEASE CIRCLE)**

HEALTH INSURANCE COVERAGE

INSURANCE #1 _____ **INSURANCE #2** _____

CONTRACT #/ ID #
OR ENROLLEE ID # _____

CONTRACT #/ ID #
OR ENROLLEE ID # _____

GROUP NUMBER _____ **GROUP NUMBER** _____

SUBSCRIBER _____ **SUBSCRIBER** _____

SUBSCRIBER DATE OF BIRTH _____ **SUBSCRIBER DATE OF BIRTH** _____

MEDICAL INFORMATION RELEASE

THE OFFICE OF DR. GANESH DESHMUKH, MD & DR. ADEWUNMI ADEYEMO, MD MAY DISCUSS MY MEDICAL CONDITION/INFORMATION WITH THE FOLLOWING:

NAME / RELATIONSHIP _____

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

THIS INFORMTION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES, CO-INSURANCES, AND SERVICES RENDERED NOT COVERED BY MY INSURANCE. I WILL BE RESPONSIBLE FOR ANY NSF FEES AND MY BALANCE MAY DEFAULT TO COLLECTIONS IF NOT PAID WITHIN 90 DAYS OF RECEIPT OF STATEMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. GANESH DESHMUKH, MD &DR. ADEWUNMI ADEYEMO, MD. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION WHEN NECESSARY. I HAVE READ THE FULL FINANCIAL POLICY AND AGREE TO THE TERMS. I HAVE BEEN GIVEN ADEQUATE ACCESS TO INFORMATION REGARDING HIPAA BY THIS OFFICE.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ **DATE** _____

Ganesh Deshmukh, MD
Adewunmi Adeyemo, MD
3106 S Wayne Rd.
Wayne, MI 48184
734-722-6300
734-722-4815 Fax

Authorization and Agreements of Medical Treatment
Insurance Benefits and Financial Responsibility

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by Ganesh Deshmukh, M.D./or Adewunmi Adeyemo, M.D. or their associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow up examinations to check abnormalities found and treated, lies with me and not my physician, thereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by Ganesh Deshmukh, M.D./or Adewunmi Adeyemo, M.D. or their associates or assistants. I hearby consent to and authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given to anyone as to the results that may be obtained by such treatments.

1. **All co-payments are due at time or service. We accept cash, check, Visa, Mastercard and Care Credit.**

2. **All balances must be paid prior to any surgeries being scheduled. This includes outpatient procedures including colonoscopy and EGD's and inpatient procedures.**

3. **Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance company are your responsibility.**

4. **You doctor is here to manage your medical care. The Physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial difficulties with the business office staff or the billing department. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.**

I have read the above Acknowledgment and Agreements and fully understand the same.

Patient's Name (Print) _____

Signature of patient or Guardian _____ Date: _____

Relationship to patient _____ Witness _____ Date: _____

Ganesh Deshmukh, MD
Adewunmi Adeyemo, MD
3106 S Wayne Rd
Wayne, MI 48184
734-722-6300
734-722-4815 Fax

By my signature, I acknowledge that I have read, understand, and agree to the policies and procedures for the offices of Dr. Deshmukh and Dr. Adeyemo.

Those policies and procedures include:

- HIPPA
- No Show / Cancellation Policy
- Phone calls
- Prescription refills
- Patient rights
- Payment / Financial policy
- Medical record requests
- FMLA / disability paperwork
- Doctor / office emergencies

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date