Mahmudul Haque, M.D., Ph.D.
Digestive Disease Care for All, LLC

Patient Demographic Sheet

Date:______________________ SS#:______________________

Last Name: ______________________ Suffix:_______ First Name:______________________ MI: ________

Date of Birth:______/______/______ Sex:___M / F___

Language:______________________ Race:______________________ Ethnicity:______________________

Driver's License #: ______________________

Address:____

City:______________________State:___________ Zip:______________

Home Phone: __(   )_____-________Work Phone:__(   )_____-________Cell Phone: _(   )______-________

Email Address: ____

Marital Status: Single / Married / Widowed / Divorced / Separated Significant other's name:______________________

Emergency Contact:______________________ Phone: ______________________

Occupation:______________________ Employer:______________________

Referred by:______________________ Phone:______________________

Primary Care Physician:______________________ Phone: ______________________

Primary Insurance:______________________ ID#:______________________

Name of Policyholder:______________________ Policyholder SS#: ______________________

Secondary Ins:______________________ ID#:______________________

Name of Policyholder:______________________ Policyholder SS#: ______________________

I hereby give consent to Mahmudul Haque, MD, PhD, to provide whatever treatment the physician assigned may deem necessary to the patient named above. I understand that I am responsible for payment of services provided to me. I understand that I am responsible for charges not covered by my insurance policy/policies. I hereby request and assign payment of authorized Medicare benefits and/or any other insurance benefits to be made on my behalf payable to Mahmudul Haque, MD, PhD/Digestive Disease Care for All, LLC for any services furnished to me by this physician and/or group. I hereby give authorization for release of medical records to my insurance company, I understand my signature request that payment be made and authorities release of medical information necessary to pay the claim. In Medicare assigned cases, the physician supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the patient is responsible for only the deductibles, coinsurance and noncovered services. Coinsurance and the deductible are based on the charge determined by the Medicare carrier.

Signature:______________________ Date:______________________

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Digestive Disease Care for All, LLC

Medical information sheet

Date:______________________________

Last Name: ______________________ Suffix:______ First Name:____________________ MI: ______

Date of Birth:______/______/______ Sex:__M / F__ Referring Physician:____________________

Reason for your visit today:______________________ Date of onset:______________

Medical Problems:

____

____

Medications:

____

____

Surgeries:

____

Allergies to medications:______________________________

Smoke:_No / Yes How much:________Alcohol use:__No / Yes_How much and what kind: ____________

Illegal drugs: No / Yes_What kind:____________________

Family history: __Diabetes / Hypertension / Cancer / Colon cancer / Other (explain)____________

Do you have any of the following symptoms/:

Frequent headaches	Y / N	Coughing Blood	Y / N	Joint pain	Y / N
Change in hearing	Y / N	Chest Pains	Y / N	Fatigue	Y / N
Dizziness	Y / N	Palpitations	Y / N	Weight loss	Y / N
Pain or Ear infections	Y / N	Blood in Stool	Y / N	Difficulty sleeping	Y / N
Change in Vision	Y / N	Diarrhea	Y / N	Change in Appetite	Y / N
Sore Throat	Y / N	Constipation	Y / N	Fever or chills	Y / N
Nose bleeds	Y / N	Urinary burning, bleeding	Y / N	Yellow Jaundice	Y / N
Hoarseness	Y / N	Backache	Y / N	Pain in Belly	Y / N
Shortness of Breath	Y / N	Muscle Pain	Y / N	Nausea / vomiting	Y / N

Any other problems not listed above:______________________________

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_________________________________ **Date of Birth:**__________________

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes:
  - Treatment
  - Payment
  - Health care operations
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise the rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:______________________________________ **Date:**__________________________________

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Mahmudul Haque, M.D., Ph.D.
Digestive Disease Care for All, LLC

Date:____________________________

I authorize:______________________________ (Company Name)

Address:__________________________________

____

____

To release Information from the medical record of:

____
(Patient's Name)

Reason for request:____

To: ***Digestive Disease Care for All, LLC (DDCA)***
Dr. Mahmudul Haque, MD, PhD. / Clinical Staff
508 E. Garden St., Lakeland, FL 33805
Phone: (863) 802-1111 Fax: (863) 802-6711

ATTN: ***Medical Records Department/Clinical Staff***

For the purpose of review / examination, I authorize you to provide the following information:

○ COMPLETE COPY OF MEDICAL RECORD ○ DISCLOSURE LOG ○ SPECIFIC INFORMATION

I give specific permission to release any information related to:

________SUBSTANCE ABUSE ________PSYCHIATRIC / MENTAL HEALTH INFORMATION

________ HIV / AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

Patient's or Legal Guardian's
Signature:____

Relationship to the patient:____

Witness:______________________________Practice:______________________________

Identifying information:
Name at the time of treatment, if other than above:______________________________

Date of Treatment:____________________ Date of Birth:____________________

SS #: ______________________________

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