VIKRAM S. JAYANTY, M.D., PA
Gastroenterology
10837 Katy Freeway • Suite 175
Houston, Texas 77079
Tel: (713) 932-9200 • Fax: (713) 932-6152

Patient Record

(Please read carefully and complete all questions)

Patient Name: ______________________________ Birthdate: _______________ Age: ______
Gender(circle one) : Male Female Social Security: ___________________________
Home Address: ____
City: ____________________________ State: ________ Zip: ________
Email: ____
Home #: ________________________ Cell#: ___________________ Work #:____________________
Marital Status: ____Single ____Married ____Divorced
Race: _______ Ethnicity: _________Preferred Language: _________
Referring Physician: _____________________________ Phone #: ____________________
Emergency Contact: ___________________ Phone #: _________________ Relationship: _______
Employment Status: ______Full-Time _____Part-Time _____Unemployed _____Retired
Employer: ____ Phone: __________________________
Employer Address: ____
Student Status: ________Full-Time ____Part-Time ______Not a student
Primary Insurance Holder Name: ____________________________ Birthdate: ______________

PLEASE READ CAREFULLY AND SIGN

This is to certify that I/we, the undersigned, herby consent to and authorize the administration of all treatments and operation, and the administration of any anesthetics, which, in the judgment of my physician may be considered necessity or advisable. I/We, the undersigned, agree to be financially responsible for the charges incurred by the patient and to make payments upon receipt of the periodic statements for the patient. In the event of non-payment, I/We agree that if the account is referred to an agency for collection I/We shall be required to pay all of the collection expense. I understand Vikram S. Jayanty M.D., PA & Anesthesia Care by Doctors LLP is in compliance with the laws and guidelines of the HIPAA regulations. All services and records are confidential and private to protect the patient.

____
Signature of Patient or Legal Guardian

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Medication Sheet

Patient Name: ______________________________ **Date of birth:** ______________

Pharmacy Name & Address: ____

Pharmacy phone number: __________________

Allergies to any medications

Medication Name	Type of Reaction

Medication list

Name of Medication	Dosage? & How often?	Reason for taking meds?	When did you start taking medication?	Prescribing Doctor's Name

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Name:______________________________ **Age:**______________
Chief Complaint:____
Duration:____

Past Medical History:(Please read carefully and complete all questions)

Diabetes?.. Yes___No___

Heart Disease?.. Yes___No___

High Blood Pressure?................ ....Yes___No___

Crohn's or colitis? (circle one) .... Yes___No___

Lung Disease?... Yes___No___

Kidney Disease?.. Yes___No___

Cancer? .... Yes___No___
If so, What kind? __________ and what age?________
Have you been tested for HIV? Yes___No___Positive ____ Negative_____
Have you been tested for Hepatitis? Yes___No___Positive ____ Negative_____
If positive what type? Type A ___ Type B____ Type C____

Have you had a colonoscopy in the past? Yes___No___
If you have when was your last colonoscopy? ______________Results: _________

Have you had any surgery performed in past? Yes___No___
When?____________________ What?__________________________________
____

Mental Health? (ex. Anxiety, depression, bi-polar) ____________________________

Vaccine Record

Have you had the Hepatitis A & B vaccine? Yes___No___
Have you had the Pneumonia vaccine? Yes___No____
Have you had Flu vaccine? Yes___No___
Have you have had a mammogram? Yes___ No___Results? ______N/A male____
Last menstrual cycle? _________ N/A male____

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Social History

What type of diet do you follow? ____________________
Do you exercise? ________________ If so how much? ________________________

Are you a smoker? _____ If so How Much? _____
If not: Former smoker___ Never a smoker________

What is your sexual preference? Heterosexual ________Homosexual______________

Do you drink alcohol? Yes___ No___ How much during a week? ___________________

Do you presently use NSAIDS (ex: Aspirin, Ibuprofen, Naprosyn)? __________________

How do you fall asleep at night? (Please Check One)
Watching TV__ Reading a book__
Reading a book on your electronic device___ Looking at your electronic device___

How many hours do you sleep each night? ________

FAMILY HISTORY

Any family member ever had any of the following **cancers** listed below?
(CIRCLE ONE THAT PERTAINS)

Colon/Rectal: .... Family Member: _________ Age_______

Uterine/endometrial: ....Family Member: __________ Age: ______

Ovarian: ....Family Member___________ Age_______

Stomach, small intestine: ....Family Member___________ Age_______

Bile duct, liver, pancreas:.............................. Family Member__________ Age ______

Other cancer:..Family Member___________ Age______

Have you or anyone in your family been tested for hereditary risk of cancer? Yes____ No____
Please explain. ____

Family History of Diabetes?... Yes___ No___
Family History of High Blood Pressure?... Yes___ No___
Family History of Heart Disease?.. Yes___ No___

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AUTHORIZATION FOR
RELEASE OF MEDICAL INFORMATION

Patient Name: ____

Date of Birth: ____________________ Social Security #: ____________________

I request that ____
release my medical records to the following:

Vikram S. Jayanty, M.D., PA

INTERVENTIONAL GASTROENTEROLOGY

BOARD CERTIFIED

10837 KATY FREEWAY, SUITE 175

HOUSTON, TEXAS 77079

Phone: (713) 932-9200 Fax: (713) 932-6152

The records requested pertain to the following:

- ☐ COLONOSCOPY
- ☐ EGD
- ☐ PATHOLOGY
- ☐ ALL RECORDS
- ☐ LABS
- ☐ IMAGING (RADIOLOGY)
- ☐ PROGRESS NOTES

Patient Signature____

Date: ____________________

Staff Use Only:

Date Sent ____/____/____
Initials: ______________

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Confidentiality Agreement

1. Please list the family members or other persons, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

   ____

   ____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

   Name____________________Phone#____________________

   Name____________________Phone#____________________

3. Please print the address of where you would like your billing statements if different from your home address.

   ____

   ____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   Yes ______ No______

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:____________________

"I am fully aware that a cell phone is not a secure and private line"

6. Can confidential messages (i.e. appointment reminders) be left on your voicemail?

   Yes______ No ________

Patient/Guardian Name__________________ (Guardian if under 18 years)

________________________________ ______________

Patient/Guardian Signature **Date**

VIKRAM S. JAYANTY, M.D.

Houston Endoscopy & ***Center***

Dr. Jayanty is dedicated to providing the best care to his patients by pursuing and researching the safest and most beneficial treatments for his patient's conditions. Dr. Jayanty has a research center that conducts research trials for major pharmaceutical companies, He has conducted over 90 clinical research trials since 1985 with new and previously approved medications that are presently on the market for the following indications: Irritable Bowel Syndrome (Diarrhea, Alternating as well as Constipation Predominant), Chronic Constipation, Reflux/Heartburn, Stomach Ulcers (healing and prevention), Duodenal Ulcers, Community Acquired Pneumonia, Acute Exacerbation of Chronic Bronchitis, Staph Vaccine in patients undergoing knee or hip replacement, Ulcerative Colitis, Crohn's Disease, Anemia, Anal Fissure and Hemorrhoids.

Dr. Jayanty has a full time dedicated and proficiently trained research staff with a combined experience in coordinating and conducting clinical trials of over 11 years.

The treatments do not require patient insurance to participate and are not charged to the patient. If you would like to be contacted and/or given more information in reference to participating in one of our trials, please complete the section below:

DO YOU GIVE CONSENT FOR YOUR CHART TO BE REVIEWED PERIODICALLY BY DR. JAYANTY'S RESEARCH STAFF FOR POSSIBLE INCLUSION INTO A CLINICAL RESEARCH TRIAL?

YES ______________ NO ______________

WOULD YOU LIKE TO BE CONTACTED VIA E-MAIL OF DR. JAYANTY'S STUDIES? PLEASE LIST E-MAIL ADDRESS: ____

ADDITIONAL INFORMATION YOU FEEL WILL BE HELPFUL IN DR. JAYANTY'S TREATMENT: ______________

____

____

PATIENT'S SIGNATURE: ______________________________________ DATE: ___________

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