Date________________________

Dear Patient

Welcome to the office of Advanced Gastroenterology Associates.

You have an appointment in our __________________ office on__________________ at____________.

If you are unable to keep this appointment, kindly give 24 hours notice as a courtesy to other patients who may need appointments. Without 24 hour notice, you may be charged a $50.00 cancellation fee.

In an effort to treat you promptly, efficiently, and within the new HIPAA Guidlines, we request the following:

1. OFFICE FORMS:
   Please complete the enclosed paperwork prior to your appointment and bring it with you on your scheduled appointment date; Please DO NOT mail. Please be advised, since this is a new practice, all patients are required to fill out this paper work upon their first visit here.

2. INSURANCE and REFERRALS:
   Please bring your most current insurance card. If your insurance requires a referral, please bring this with you on the day of your appointment. Without your referral, your appointment will need to be rescheduled.

3. YOUR PICTURE ID:
   Please bring picture ID with you on the day of your appointment.

4. CO-PAYS:
   Co-pays are required at the time of your appointment. We accept cash, checks, Visa, Mastercard, and American Express.

5. PRIOR MEDICAL RECORDS:
   Please bring with you any records and/or test test results that pertain to the reason for your appointment with us. This may include blood tests, CT Scans, MRIs, Ultrasounds, or any records from a previous gastroenterologist.

We thank you for your cooperation and look forward to seeing you.
Today's Date: ________________________ DOB: ________________________ Age: ________________________

Name: ______________________________ Referring Physician ______________________________

Reason for today's visit: ________________________________________________________________

Please check if medications are the same since your last visit: ______

Please list any NEW medications and dosages: ____________________________________________

Please note any discontinued medications: ______________________________________________

Have you had any recent hospitalizations / surgeries? If so, when, where and why?
_________________________________________ __________________________________________

Have you had any new diagnosis(es) since your last visit? If so, please list:
_________________________________________ __________________________________________

Please list any drug allergies: ________________________________________________________

LATEX ALLERGY?  Y  N

PLEASE DO NOT WRITE BELOW THIS LINE; FOR YOUR DOCTOR'S USE ONLY.

Blood Pressure ________________________ Weight ________________________ Height __________
PLEASE COMPLETE ALL INFORMATION

Name________________________________________ Birthdate / / SSN____-____'
Address_____________________________________ City _______________ State__ Zip____

Telephone numbers:
Home ___________________ Work ________________ ext____ Cell______________
Employer ________________________ Marital Status: S M W D  Sex: M F
Pharmacy ________________________ Pharmacy Telephone ______________

Primary Insurance ___________________________ ID __________________ Group____
Insurance Effective Date______________________
Insurance Co. Address_____________________ Insurance Co. Telephone ________
Policy Holder’s Name _______________________ Relationship to patient __________
Address if different from patient ______________
Policy Holder’s Home Telephone ______________ SSN____-____-____ Birthdate / / /
Policy Holder’s Employer ______________________ Telephone ______________ ext.__

Secondary Insurance __________________________ ID __________________ Group____
Insurance Effective Date______________________
Insurance Co. Address_____________________ Insurance Co. Telephone ________
Policy Holder’s Name _______________________ Relationship to patient __________
Address if different from patient ______________
Policy Holder’s Home Telephone ______________ SSN____-____-____ Birthdate / / /
Policy Holder’s Employer ______________________ Telephone ______________ ext.__

Emergency Contact Numbers:
Emergency Contact __________________________ Relationship ____________________
Home ___________________ Work ________________ ext____ Cell______________
Patient’s Primary Medical Doctor __________________________
Address _______________________ Phone ________
Who referred you to our office? __________________________

Patient/Guardian Signature __________________________ Date ________________

Michael R. Tendler, M.D.
Barbara Cencora, M.D.
Jared Z. Gold, M.D.
Suresh Pitchumoni, M.D.
Tina A. Vazirani, M.D.

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403 Candlewood Commons, Building #4, Howell, NJ 07731
100 Perrine Road, Old Bridge, NJ 08857
Tel. 732-370-2220 • Fax: 732-548-7408
www.advancedgastroonline.com
Patient Interview Form

Patient Information

First Name: __________________________ Last Name: __________________________
MRN: __________________________ Date Of Birth: __________________________
Age: __________________________ Notes: __________________________

Email
Please check one as your preferred email for communications
☐ Personal: __________________________ ☐ Work: __________________________

Contact Preference
☐ Cell number ☐ Patient Portal HIPAA compliant email
☐ Home Number ☐ Patient declines to specify
☐ Other: __________________________

Race
Select one or more
☐ White ☐ Black or African American
☐ Asian ☐ American Indian or Alaska Native
☐ Unknown ☐ Native Hawaiian or Other Pacific Islander
☐ Patient declines to specify

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Patient declines to specify

Sex
☐ Male ☐ Female ☐ Other

Preferred Language
☐ English ☐ Polish ☐ Spanish; Castilian
☐ Patient declines to specify

Form 5A
(6pgs) Rev 6-18-2015
Allergies

☐ Patient has no known allergies
☐ Patient has no known drug allergies

- Aspirin (Tartrazine Only)
- Milk
- Latex
- Penicillins
- NSAIDs (Non-Steroidal Anti-Inflammatory Drug)
- Band-Aids
- Iodine IV Dye
- Codeine Sulfate
- Kiwi
- Eggs
- Bactrim
- Sulfa (Sulfonamide Antibiotics)
- Peanuts

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes  ☐ No

Pharmacy

Name  Address  Phone

Current Medications

☐ None

Name  Dose  How taken?

Immunizations

☐ None

- Hep A, adult
- Hep B
- HPV
- Flu vaccine
- MMR
- Pnuemovax
- tetanus toxoid
- varicella

Diagnostic Studies/Tests

☐ None

- Abdominal Ultrasound
- Colonoscopy
- CT Abdomen/Pelvis
- EGD
- ERCP
- EUS
- Flexible Sigmoidoscopy
- Mammography
- MRI Abdomen/Pelvis
- Small Bowel Imaging

Previous Procedures

☐ None

- Appendectomy
- C-Section
- Cardiac stent
- Colon Resection
- Gall Bladder Removal
- Hysterectomy
- Lung Bx
- Obesity Surgery
- Defibrillator
- Pacemaker

When:

When:

When:

When:

When:

When:

When:

When:
Past or Present Medical Conditions

- None
- Acid Reflux
  - When:
- Arrhythmia
  - When:
- Arthritis
  - When:
- Asthma
  - When:
- Celiac Disease
  - When:
- Cirrhosis
  - When:
- Colon cancer
  - When:
- Colon polyps
  - When:
- Congestive Heart Failure
  - When:
- COPD
  - When:
- Coronary artery disease
  - When:
- Crohn's Disease
  - When:
- Depression
  - When:
- Diverticulitis
  - When:
- Diabetes Mellitus, insulin dependent
  - When:
- Elevated cholesterol
  - When:
- Gout
  - When:
- Heart Attack
  - When:
- Hepatitis B
  - When:
- Hepatitis C
  - When:
- HIV
  - When:
- Hypertension
  - When:
- Hyperthyroidism
  - When:
- Hypothyroidism
  - When:
- IBS
  - When:
- Kidney Disease
  - When:
- Liver Disease
  - When:
- MRSA
  - When:
- Osteopenia
  - When:
- Osteoporosis
  - When:
- Seizures
  - When:
- Sleep apnea
  - When:
- Stroke (CVA)
  - When:
- Transient Ischemic Attack
  - When:
- Ulcerative Colitis
  - When:
- Valvular heart disease
  - When:
- Other:

Social History

Occupation: __________________________ Number of Children: ______________________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed

- Civil Union
- Unknown
- Other

Alcohol

- None

<table>
<thead>
<tr>
<th>Type</th>
<th>Quantity</th>
<th>Number</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer</td>
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<tr>
<td>Hard Liquor</td>
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<tr>
<td>Wine</td>
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</table>

Caffeine

- None

<table>
<thead>
<tr>
<th>Soft Drink</th>
<th>Tea</th>
<th>Chocolate</th>
<th>Coffee</th>
</tr>
</thead>
</table>

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Exercise

- None

<table>
<thead>
<tr>
<th>Type</th>
<th>Quantity</th>
<th>Number</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
### Drug Use
- [ ] None
- [ ] Recreational Drug Use

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Number</th>
<th>Frequency</th>
</tr>
</thead>
</table>

### Family Medical History
- [ ] No knowledge of family history
- [ ] No family history of Colon cancer
- [ ] Polyps

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

### Health Status
- [ ] Alive
- [ ] Deceased/At Age

<table>
<thead>
<tr>
<th>Cause of Death</th>
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<tbody>
<tr>
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</tbody>
</table>

### Diagnoses
- Barrett's Esophagus
- Breast Cancer
- Colon Polyps
- Colorectal Cancer
- Esophageal Cancer
- Gynecologic Cancers
- Liver Cancer
- Liver Disease
- Lung Cancer
- Pancreatic Cancer
- Prostate Cancer
- Stomach Cancer
- Ulcerative colitis/Crohn's Disease
- Other:
### Review Of Systems

<table>
<thead>
<tr>
<th>Allergic/Immunologic</th>
<th>Y N</th>
<th>Genitourinary</th>
<th>Y N</th>
<th>Psychiatric</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td>None</td>
<td></td>
<td>None</td>
<td></td>
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<tr>
<td>HIV exposure</td>
<td></td>
<td>dark urine</td>
<td></td>
<td>anxiety</td>
<td></td>
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<tr>
<td>persistent Infections</td>
<td></td>
<td>decrease in urine flow</td>
<td></td>
<td>depression</td>
<td></td>
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<tr>
<td>strong allergic reactions or urticaria</td>
<td></td>
<td>dysuria</td>
<td></td>
<td>difficulty sleeping</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Y N</td>
<td>frequent urinary infections</td>
<td>Y N</td>
<td>hallucinations</td>
<td></td>
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<tr>
<td>chest pain</td>
<td></td>
<td>frequent urination</td>
<td></td>
<td>nervousness</td>
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<tr>
<td>become very short of breath with normal exercise</td>
<td></td>
<td>hematuria</td>
<td></td>
<td>panic attacks</td>
<td></td>
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<tr>
<td>irregular heart beat</td>
<td></td>
<td>impotencia</td>
<td></td>
<td>paranoia</td>
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<td>orthopnea</td>
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<td>nocturia</td>
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<tr>
<td>palpitations</td>
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<td>urethral discharge or incontinence</td>
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<tr>
<td>peripheral edema</td>
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<td>ENMT</td>
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<td>None</td>
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<tr>
<td>difficulty swallowing</td>
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<td>dizziness</td>
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<td>ear pain</td>
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<td>nose bleeds</td>
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<td>sore throat</td>
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<td>excessive thirst</td>
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<td>hair loss</td>
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<td>heat intolerance</td>
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<td>Eyes</td>
<td>Y N</td>
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<tr>
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<td>sensitivity to light</td>
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<td>Gastrointestinal</td>
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<td>heartburn</td>
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<td>abdominal swelling</td>
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<td>change in bowel habits</td>
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<tr>
<td>constipation</td>
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<tr>
<td>diarrhea</td>
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<td>gas</td>
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<td>jaundice</td>
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<td>nausea</td>
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<tr>
<td>rectal bleeding</td>
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<tr>
<td>stomach cramps</td>
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<tr>
<td>vomiting</td>
<td></td>
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</tbody>
</table>
Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

______________________________  ____________________
Signature                    Date
PATIENT FINANCIAL RESPONSIBILITY STATEMENT

We are pleased you have chosen our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In exchange for providing these services, we ask that you take the time to understand your financial responsibilities to ensure timely and acceptable payment for our services.

1. I am responsible for knowing the details of my insurance coverage(s), including my responsibility for co-payments, deductibles, co-insurances, and referrals. I will call my insurance company to obtain this information.

2. I authorize payment of my insurance benefits to Allied Digestive Health for the medical services received.

3. I accept responsibility for payment of any amounts (co-payments, deductibles, and co-insurance) that are not covered by my insurance(s).

4. I will provide all current insurance information (we require both sides of your insurance card(s)) at the time of service as well as a photo ID.

5. I agree to have a current and active insurance referral (if applicable) issued by my primary care physician (PCP) at the time of service. Without this referral, my appointment may be canceled, rescheduled or I will pay the full fee for my appointment. A doctor's prescription is not a valid insurance referral.

6. If I have an endoscopy procedure, I may be responsible for the following fees:
   a) Gastroenterologist's fee
   b) Facility fee (billed by the endoscopy center and/or hospital)
   c) Pathology fee for any tissue biopsy/testing
   d) Anesthesiologist's fee

7. Colonoscopies are not always screening colonoscopies and may not be covered in full by my insurance. I understand I am responsible for any balance left unpaid by insurance. Allied Digestive Health will not/cannot change the diagnosis (please see the attached "Screening Colonoscopy vs Diagnostic").

8. If I am without insurance coverage, Allied Digestive Health expects to be paid at the time services are rendered.

9. I understand after three (3) attempts to collect any patient balance, my account will be turned over to a collection agency. I will also be responsible for any and all fees and service charges incurred as a result of a collection agency's involvement.

10. I understand I will be charged a $35.00 fee if my personal check is returned by my bank.

I HAVE READ THE ABOVE STATEMENTS AND FULLY UNDERSTAND AND AGREE TO THESE TERMS.

Patient's Name (Please Print) ___________________________________________

Patient's Signature ___________________________________________________

Responsible Party/Guardian _____________________________________________

Date ________________

475 County Road 520, Baron Plaza, Suite 201, Marlboro, NJ 07746
403 Candlewood Commons, Building #4, Howell, NJ 07731
100 Perrine Road, Old Bridge, NJ 08857

Tel. 732-370-2220 • Fax: 732-548-7408
www.advancedgastroonline.com
CONSENTS

(1) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, we will not discuss your medical situation, test results, or billing information with anyone but you over the phone. However, with your consent, we will speak to your spouse or a close family member about your situation. Please understand that you are waiving your right of confidentiality if you give your permission.

______ INITIAL HERE TO GIVE CONSENT: I consent for the physicians and/or office staff to discuss my medical condition and test results with my spouse or close family member that I have listed below.

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, we would ordinarily not leave results on your answering machine, however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

______ INITIAL HERE TO GIVE YOUR CONSENT: I consent for the physicians and/or office staff to leave medical results on my telephone answering machine.

I have read and understood the above material.

Patient Signature ____________________________ Date: ____________________________