ADVANCED GASTROENTEROLOGY ASSOCIATES *A Division of Allied Digestive Health*

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

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.

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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 _____

475 County Road 520, Baron Plaza, Suite 201, Marlboro, NJ 07746
403 Candlewood Commons, Building #4, Howell, NJ 07731
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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 _____

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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 ☐ Native Hawaiian or Other Pacific Islander

☐ Unknown ☐ 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

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Aspirin (Tartrazine Only)
- ☐ Penicillins
- ☐ Codeine Sulfate
- ☐ Bactrim
- ☐ Sulfa (Sulfonamide Antibiotics)
- ☐ Milk
- ☐ Nsaids (Non-Steroidal Anti-Inflammatory Drug)
- ☐ Kiwi
- ☐ Eggs
- ☐ Peanuts
- ☐ Latex
- ☐ Band-Aids
- ☐ Iodine IV Dye
- Other: _____

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 — When: _____
- ☐ Hep B — When: _____
- ☐ HPV — When: _____
- ☐ Flu vaccine — When: _____
- ☐ MMR — When: _____
- ☐ Pnuemovax — When: _____
- ☐ tetanus toxoid — When: _____
- ☐ varicella — When: _____
- Other: _____

Diagnostic Studies/Tests

- ☐ None
- ☐ Abdominal Ultrasound — When: _____
- ☐ Colonoscopy — When: _____
- ☐ CT Abdomen/Pelvis — When: _____
- ☐ EGD — When: _____
- ☐ ERCP — When: _____
- ☐ EUS — When: _____
- ☐ Flexible Sigmoidoscopy — When: _____
- ☐ Mammography — When: _____
- ☐ MRI Abdomen/Pelvis — When: _____
- ☐ Small Bowel Imaging — When: _____

Previous Procedures

- ☐ None
- ☐ Appendectomy — When: _____
- ☐ C-Section — When: _____
- ☐ Cardiac stent — When: _____
- ☐ Colon Resection — When: _____
- ☐ Gall Bladder Removal — When: _____
- ☐ Hysterectomy — When: _____
- ☐ Lung Bx — When: _____
- ☐ Obesity Surgery — When: _____
- ☐ Defibrillator — When: _____
- ☐ Pacemaker — 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:_____
- [ ] Diabetes Mellitus, non-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

Type	Quantity	Number	Frequency
[ ] Beer			
[ ] Hard Liquor			
[ ] Wine			

Caffeine

- [ ] None
- [ ] Soft Drink
- [ ] Tea
- [ ] Chocolate
- [ ] Coffee

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

Type	Quantity	Number	Frequency

Drug Use

○ None

	Type	Quantity	Number	Frequency
○	Recreational Drug Use			

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

Health Status	Mother	Father	Sister	Brother
Alive	○	○	○	○
Deceased/At Age	○ ____	○ ____	○ ____	○ ____
Cause of Death	____	____	____	____

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

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
become very short of breath with normal excercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
sensitivity to light	○	○

Gastrointestinal

None	Y	N
difficulty swallowing	○	○
heartburn	○	○
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

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

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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) _____ Responsible Party/Guardian _____

Patient's Signature _____ Date _____

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CONSENTS

(I) 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:_____

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