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.
Amy Tilara, 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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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**

475 County Road 520, Baron Plaza, Suite 201, Marlboro, NJ 07746
59 Kent Road, Howell, NJ 07731
100 Perrine Road, Old Bridge, NJ 08857
Tel. 732-370-2220 • Fax: 732-548-7408
www.advancedgastroonline.com

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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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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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HIPAA Notice of Privacy Practices

***Effective Date* 09/2013**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact our office manager.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our Medical Records department. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office manager.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our medical records department.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the office manager. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the office manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.advancedgastroonline.com. To obtain a paper copy of this notice, please call (732) 370-2220.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

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ACKNOWLEDGMENT

I acknowledge that I have been provided with a copy of Advanced Gastroenterology Associates Privacy Notice and have been given an opportunity to read and ask questions about this notice.

Date: _____

Print Patient's Name: _____

Patient's Signature: _____

Witness: _____

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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 ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

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
- ☐ Penicillins
- ☐ Codeine Sulfate
- ☐ Bactrim
- ☐ Sulfa (Sulfonamide Antibiotics)
- ☐ Milk
- ☐ Nsaids (Non-Steroidal Anti-Inflammatory Drug)
- ☐ Kiwi
- ☐ Eggs
- ☐ Peanuts
- ☐ Latex
- ☐ Band-Aids
- ☐ Iodine And Iodide Containing Products
- 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: _____
- ☐ Pneumococcal conjugate PCV 13 — When: _____
- ☐ tetanus toxoid — When: _____
- ☐ varicella — When: _____
- Other: _____

Diagnostic Studies/Tests

☐ None

- ☐ Abdominal Ultrasound — When: _____
- ☐ Bone densitometry (DEXA) — 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:_____
☐ Urinary Incontinence 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 Recreational Drug Use

Quantity Number Frequency

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	○	○
bleeding	○	○
anorectal swelling	○	○
rectal prolapse	○	○
anal itching	○	○
incomplete fecal evacuation	○	○
rectal pain	○	○
Any structural abnormalities of the upper GI tract	○	○
Any inflammatory diseases of the upper GI tract	○	○
Cirrhosis or hepatic insufficiency	○	○
Known motility disorder	○	○
Patients who can't tolerate or take PPI (allergy)	○	○
Current intractable GERD / Acid reflux symptoms	○	○
Any prior gastrointestinal surgery	○	○
Any prior bariatric surgery	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
Urinary Incontinence	○	○
Urinary Discharge	○	○

Hematologic/Lymphatic

○ None	Y	N
easy bruising	○	○
prolonged bleeding	○	○
bleeding gums	○	○
palpable lymph nodes	○	○
Known coagulopathy or bleeding disorders	○	○
pts taking aspirin not under medical supervision	○	○
pts taking advil not under medical supervision	○	○
pts taking anti-coag not under medical supervision	○	○

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	○	○
Alcoholism or drug addiction	○	○
Severe psychiatric illness	○	○

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

ADVANCED GASTROENTEROLOGY ASSOCIATES *A Division of Allied Digestive Health*

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Tina A. Vazirani, M.D.
Amy Tilara, M.D.

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 _____

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