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.
Ahmed Alansari, M.D.

Patient Registration Form

Please Complete All Information

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ M.I.: ______

Date of Birth ___/___/___ Age: _____ SSN: ____-____-____ Sex: M / F Marital Status: S M D W

Address: ______________ City: __________ State: ______ Zip Code: ______

Email: ______________ Home Phone: __________ Cell Phone: __________

Occupation: ______________ Employer: ______________

Emp. Address: ______________ Emp. Phone: ______________

Primary Care Physician: ______________ Referring Physician: ______________

Pharmacy Name: ______________ Pharmacy Address: ______________

Pharmacy Phone: ______________ Rx Card Number: ______________

Emergency Contact: ______________ **Relationship to Patient:** ______________

Emergency Contact Primary Phone: ______________ Secondary Phone: ______________

PRIMARY INSURANCE

Please also provide a copy of insurance card

Insurance Carrier: ______________ Policy ID # ______________ Group # ______

Insurance Effective Date: ___/___/___ Insurance Co Phone ______________

Insurance Address: ______________

Subscriber's Name: ______________ Relationship to Patient: ______________

Address if different from patient: ______________ City: __________ State: ______ Zip Code: ______

Subscriber's Phone # __________ Subscriber's Date of Birth: ___/___/___ SSN: ____-____-____

Subscriber's Employer ______________

SECONDARY INSURANCE

Please also provide a copy of insurance card

Insurance Carrier: ______________ Policy ID # ______________ Group # ______

Insurance Effective Date: ___/___/___ Insurance Co Phone ______________

Insurance Address: ______________

Subscriber's Name: ______________ Relationship to Patient: ______________

Patient/Guardian Signature: ______________ **Date:** ______________

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Consent for Use and Disclosure of Protected Health Information (PHI)

Use and Disclosure of PHI

Your PHI will be used by Advanced Gastroenterology Associates, a Division of Allied Digestive Health (ADH), or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of the practice.

Requesting a Restriction on the Use or Disclosure of your Information

You may request a restriction on the use or disclosure of your protected health information. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restriction will be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction, and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

Primary Telephone # ______________________________

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing.**

Secondary Phone # ______________________________

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing.**

Other persons authorized to receive my health information:

Name: ______________________________ Relationship: ____________________

Phone: ____________________

Name: ______________________________ Relationship: ____________________

Phone: ____________________

Revocation of Consent

You may revoke this consent in the use and disclosure of you Protected Health Information at any time. You may revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose my Protected Health Information in accordance with these guidelines.

______________________________ ______/______/______

Signature of Patient or Patient Representative Date

______________________________ ______________________________

Printed Name of Patient or Patients Representative Patient Date of Birth

475 County Road 520, 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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Patient Financial Responsibility Statement

We are pleased that 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. A doctor's prescription is not a valid **insurance** referral. I will call my insurance company to obtain this information.

2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurance, deductibles and non-covered services.

3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees for services rendered and that unless other arrangements have been made in advance, payment of these fees is expected in full at the time of service.

4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.

5. I will provide all current insurance information (we require both sides of your insurance cards) at the time of service, including a photo ID.

6. 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.

X_______________________________ X_______________________________
Print Patient Name Responsible Party/Guardian

X_______________________________ X_______________________________
Patient Signature Date

Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Allied Digestive Health for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. I understand that I am financially responsible for payment of all services regardless of any payment issued by my carrier or not. A photocopy of this authorization shall be considered as effective and valid as the original.

_______________________________ _______________________________
Signature of Patient or Guardian Today's Date

Release of Medical Records and Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company or their authorized third parties involved in my case unless I have specifically instructed otherwise.

_______________________________ _______________________________
Signature of Patient or Guardian Today's Date

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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____________________

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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

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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	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	O	O	O	O
Deceased/At Age	O ____	O ____	O ____	O ____
Cause of Death	____	____	____	____
Diagnoses				
Barrett's Esophagus	O	O	O	O
Breast Cancer	O	O	O	O
Colon Polyps	O	O	O	O
Colorectal Cancer	O	O	O	O
Esophageal Cancer	O	O	O	O
Gynecologic Cancers	O	O	O	O
Liver Cancer	O	O	O	O
Liver Disease	O	O	O	O
Lung Cancer	O	O	O	O
Pancreatic Cancer	O	O	O	O
Prostate Cancer	O	O	O	O
Stomach Cancer	O	O	O	O
Ulcerative colitis/Crohn's Disease	O	O	O	O
Other:	O	O	O	O

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.

- [x] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature

Date