AIG
Affiliates in Gastroenterology

Today's Date: _____

Last Name: _____ First Name: _____ Middle _____ (Medicare requirement)

Address: _____ Address 2:_____ City:_____ State: ___ Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Which is the best to reach you? _____ Where can we leave a message? _____

Birthdate: _____ Social Security #: _____ Email: _____

Sex: M F Pronoun: She/Her He/Him They/Them Marital Status: Single Married Divorced Widow

Occupation: _____ Employer :_____

Referring Physician: _____ Primary Doctor: _____

Pharmacy Name: _____ City & State: _____ Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Responsible Party Information, If other than patient

Name: _____ Relationship: _____ Phone: _____

Address: _____ Address 2:_____ City:_____ State: ___ Zip: _____

Date of birth: _____Employer: _____ Phone: _____

Insurance Information - If your insurance card is provided to the staff, you may skip this section

Primary Insurance: _____ Subscriber/ID #: _____ _____

Group #: _____ Address: _____ City:_____ State: ___ Zip: _____

Phone: _____ Does your insurance require a referral from your primary doctor? ○ Yes ○ No

(Referrals must be presented at the time of your visit) (It is your responsibility to get a referral if required)

Secondary Insurance: _____ Subscriber/ID #: _____

Group #: _____ Address: _____ City:_____ State: ___ Zip: _____

Phone: _____

Notice of Privacy Practices

You may contact us with any concerns or for additional information regarding our privacy practices by calling or writing the Privacy Officer at 101 Old Short Hills Rd, Suite 217 West Orange, NJ 07052 Phone: 973-731-4600

I acknowledge that the Notice of Privacy Practices from Affiliates in Gastroenterology was available to me.

Printed Name: _____ Signature: _____ Date: _____

Please complete the reverse side of this form. Signatures are required.

AIG
Affiliates in Gastroenterology

Today's Date: _____

Cancellation Policy

While we do NOT have a cancellation fee, we ask that you please provide sufficient notice (preferably 24 hours) so we can accommodate other patients. Two consecutive no-shows and frequent cancellations may result in a discharge from our practice. Appointments are in high demand and your early cancellation will give another person the ability to have access to his/her gastroenterologist. This policy enables the doctors to utilize available appointments for patients needing their care.

By signing, I acknowledge the terms of this agreement.

Printed Name: _____ Signature: _____ Date: _____

Designation of Certain Relatives, Close Friends, and Other Caregivers

I agree that Affiliates in Gastroenterology, P.A. may disclose certain health information to a family member, close personal friend, or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, Affiliates in Gastroenterology, P.A. will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my healthcare. I designate the following persons involved with my health care or payment relating to my healthcare for the purpose of Affiliates in Gastroenterology, P.A. making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name(s) and date of birth: _____

_____

The staff and/or physicians/providers of Affiliates in Gastroenterology, P.A. may need to contact you regarding appointments. Results of tests, return phone calls, etc.

With whom may we leave a message for you to contact this office? (Please list name and relationship to you)

_____

_____

Do you have any other instructions? _____

_____

I request that payment of authorized insurance benefits be made to Affiliates in Gastroenterology, P.A. for services provided to me by the provider. I authorize the release to any referring physician or appropriate insurance company of any medical information acquired in the course of my examination or treatment. I understand that I am financially responsible for any co-pay, deductible, co-insurance, and non-covered expenses.

Printed Name: _____ Signature: _____ Date: _____

AFFILIATES IN GASTROENTEROLOGY, P. A.

Medical History

Name: _____Today's Date: _____

Birthdate: _____ Referring Doctor: _____

Current symptoms or problem: _____

Duration: _____

Medical Problems/Past Medical History (i.e. high blood pressure, diabetes, ulcers, cancer, hepatitis, colitis, etc)

_____ _____

_____ _____

_____ _____

Previous Surgeries (with dates):

_____ _____

_____ _____

Medications, Vitamins, Supplements (with strength and dosage):

_____ _____

_____ _____

_____ _____

_____ _____

Do you have any allergies to medications ☐Yes ☐No What Medicine? _____

If yes, describe reaction: _____

Do you use aspirin, Advil, Motrin, etc? _____How often? _____

Do you take a blood thinner? ☐Yes ☐No If yes, which one? _____

Do you have a pacemaker? ☐Yes ☐No Defibrillator? ☐Yes ☐No

Have you ever had a colonoscopy? ☐Yes ☐No When? _____

Have you ever had an upper endoscopy? ☐Yes ☐No When? _____

Have you had your flu vaccine? ☐Yes ☐No When? _____

Have you had the Prevnar (Pneumococcal) vaccine? ☐Yes ☐No When? _____

When was your last pap smear? (Women) ☐Yes ☐No When? _____

When was your last mammogram? (Women) ☐Yes ☐No When? _____

Do you smoke? ☐Yes ☐No If yes, How many cigarettes per day? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much per week? _____

Do you use Recreational Drugs? ☐Yes ☐No If yes, substance and how Often? _____

Have you had a blood transfusion? ☐Yes ☐No If yes, when? _____

Any family diseases? (i.e., cancer, heart, diabetes, colitis, liver) If so, whom? _____

_____

Please complete page 2 (on the opposite side)

AFFILIATES IN GASTROENTEROLOGY, P. A.

Medical History

Do you now have or have you ever had:			When, Frequency, Duration, etc.
Painful Swallowing	☐ Yes	☐ No	
Heartburn	☐ Yes	☐ No	
Gas Pain	☐ Yes	☐ No	
Abdominal Pain	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Diarrhea	☐ Yes	☐ No	
Hemorrhoids	☐ Yes	☐ No	
Colitis	☐ Yes	☐ No	
Rectal Bleeding	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	
Dizziness	☐ Yes	☐ No	
Vertigo (room spinning)	☐ Yes	☐ No	
Visual Disturbances	☐ Yes	☐ No	
Eye Pain	☐ Yes	☐ No	
Hearing Difficulty	☐ Yes	☐ No	
Skin Problems	☐ Yes	☐ No	
Rash or Hives	☐ Yes	☐ No	
Swollen Glands	☐ Yes	☐ No	
Recurrent Sore Throat	☐ Yes	☐ No	
Thyroid Problems	☐ Yes	☐ No	
Post Nasal Drip	☐ Yes	☐ No	
Cough (chronic)	☐ Yes	☐ No	
Shortness of Breath	☐ Yes	☐ No	
Asthma/Wheezing	☐ Yes	☐ No	
Chest Pain	☐ Yes	☐ No	
Palpitations	☐ Yes	☐ No	
Difficulty or Pain Urinating	☐ Yes	☐ No	
Excessive Thirst	☐ Yes	☐ No	
Excessive Urination	☐ Yes	☐ No	
Weight Loss (recent)	☐ Yes	☐ No	
Weight Gain (recent)	☐ Yes	☐ No	
Abnormal Menses (women)	☐ Yes	☐ No	
Joint Pain	☐ Yes	☐ No	
Back Pain	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Easy Bruising/Bleeding	☐ Yes	☐ No	
Seasonal Allergies	☐ Yes	☐ No	
Food Sensitivity	☐ Yes	☐ No	

Print Patient's Name: _____ **Signature:** _____