Red Bank Gastroenterology
A Division of Allied Digestive Health
365 Broad Street Red Bank, New Jersey 07701
T: 732-842-4294 F: 732-548-7408 www.rbgastro.com

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Board Certified in Gastroenterology

Patient Name:_____ MRN #:_____

Appointment Date:_____ /_____ /____ / _____
Day of the Week Month Day Year

Time of Appointment: _____ Suggested Arrival Time: _____
30 min. prior to appointment time

Dear Valued Patient,
In order for us to process your visit in a timely manner, it is necessary that you ***complete your paperwork*** prior to your arrival on the day of your appointment.

Please bring the following:

- ☐ Completed Paperwork
- ☐ Your Insurance Card
- ☐ Your Rx Card
- ☐ Your Driver's License for verification purposes
- ☐ Your Co-Pay, if applicable, is due at the time of service
- ☐ Referral if needed
- ☐ Blood Work / Hospital Stays / CT Scan / MRI Scan / Ultrasound / any other pertinent information that will assist in our physician providing you with the best care

Without these documents, we may not be able to provide you with service.

INSURANCE
We participate with most insurances, however, it is best that you verify with your insurance company if we are In-Network with your insurance carrier (we are listed as division of Allied Digestive Health with the insurance carriers), or if you have out-of-network benefits where you would pay for your office visit and the insurance company will reimburse you. Please be advised that we do ***not*** participate with ***Medicaid*****.**

CANCELLATION
All cancellations must be done within a 24 hours period in order to avoid a penalty fee.

We look forward to your visit.

Allied Digestive Health

Patient Registration Form

Please Complete All Information

Appointment Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: ____/____/____ Age: _____ SSN: ____-____-____ Sex: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Pref. Language: _____

Address: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer 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 provide a copy of insurance card.

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Insurance Effective Date: ____/____/____ Insurance Co Phone: _____

Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Address (if different from patient): _____ Subscriber's Phone: _____

Subscriber's Date of Birth: ____/____/____ SSN: ____-____-____ Subscriber's Employer: _____

Secondary Insurance Please provide a copy of insurance card.

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Insurance Effective Date: ____/____/____ Insurance Co Phone: _____

Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

How did you hear about our practice? _____

_____ _____

Signature of Patient or Guardian Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Practice Administrator who serves as the Privacy Officer.

Allied Digestive Health

PATIENT ACKNOWLEDGEMENT OF
THE NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that Allied Digestive Health's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Allied Digestive Health

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

Use and Disclosure of PHI

Your PHI will be used by Allied Digestive Health, 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

Allied Digestive Health

Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: _____

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
   Please note: a Doctor's Prescription is NOT a valid Referral.

2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, 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 provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.

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 (we require both sides of your insurance card) at the time of service as well as a current photo ID.

6. I understand that I will be charged $35 for any check returned by my bank for any reason.

BY MY SIGNATURE BELOW, I ACKNOWLEGE THAT I UNDERSTAND AND AGREE TO THESE TERMS:

_____ _____

Signature of Patient or Guardian Today's Date

Allied Digestive Health

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 insurance 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 authorizes 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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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 only ☐Any method ☐Patient Portal HIPPA compliant email ☐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 0Spanish/Castilian ☐Patient declines to specify

ALLERGIES

☐Patient has no known allergies

DPatient has no known drug allergies

DAsprin *Tartrazine only* ☐Penicillins ☐Codeine Sulfate DBactrim/Sulfa ☐Milk ☐NSAID's ☐Kiwi

☐Eggs ☐Peanuts ☐Latex ☐Band-Aids ☐Morphine **D**Iodine Injectable 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_____ Name_____ Name_____
dose_____ dose_____ dose_____

Name_____ Name_____ Name_____
dose_____ dose_____ dose_____

IMMUNIZATIONS

None

Hep A *when*_____ Hep B *when*_____ HPV *when*_____ Flu Vaccine *when*_____ MMR *when*_____

Pneumovax *when*_____ Tetanus *when*_____ Varicella *when*_____ Other *when*_____

DIAGNOSTIC STUDIES / TESTS

None

Abdominal Ultrasound *when*_____ Colonoscopy *when*_____ CT Abdomen/Pelvis *when*_____ EGD *when*_____ ERCP *when*_____

EUS *when*_____ Flexible Sigmoidoscopy *when*_____ Mammogram *when*_____ MRI Abdomen/Pelvis *when*_____ Small Bowel Imaging *when*_____

Other _____
*when*_____

PREVIOUS PROCEDURES

None

Appendectomy *when*_____ C-Section *when*_____ Cardiac Stent *when*_____ Colon Resection *when*_____ Defibrillator *when*_____

Gall Bladder Removal *when*_____ Hysterectomy *when*_____ Lung Surgery *when*_____ Obesity Surgery *when*_____ Pacemaker *when*_____

Other _____
*when*_____

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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* _____

C.O.P.D. *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* _____

Irritable Bowel Syndrome *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* _____

Valvular Heart Disease *when* _____

Ulcerative Colitis *when* _____

Other _____ *when* _____

SOCIAL HISTORY

Occupation_____Number of Children_____

MARITAL STATUS

Single Married Divorced Separated Widowed

Civil Union Unknown Other

ALCOHOL

None

	Quantity	Number	Frequency
Beer	_____	_____	_____
Hard Liquor	_____	_____	_____
Wine	_____	_____	_____

CAFFEINE

None

Coffee Soft Drink Tea Chocolate

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TOBACCO

D Current every day smoker D Current some day smoker D Former smoker D Never smoker

D Smoker, current status unknown D Light tobacco smoker D Heavy tobacco smoker D Unknown if ever smoked

DRUG USE

D None

	Quantity	Number	Frequency
D Recreational Drug Use:			
_____	_____	_____	_____

EXERCISE

D None

	Quantity	Number	Frequency
D Type			
_____	_____	_____	_____

FAMILY MEDICAL HISTORY

D No knowledge of family history

No family history of D Colon Cancer D Polyps

HEALTH STATUS

	Mother	Father	Sister	Brother
Alive	D	D	D	D
Deceased/Age	D____	D____	D____	D____
Cause of Death	_____	_____	_____	_____

DIAGNOSES

Barrett's Esophagus	D	D	D	D
Breast Cancer	D	D	D	D
Colon Polyps	D	D	D	D
Colorectal Cancer	D	D	D	D
Esophageal Cancer	D	D	D	D
Gynecologic Cancer	D	D	D	D
Liver Cancer	D	D	D	D
Liver Disease	D	D	D	D
Lung Cancer	D	D	D	D
Pancreatic Cancer	D	D	D	D
Prostate Cancer	D	D	D	D
Stomach Cancer	D	D	D	D
Ulcerative Colitis/ Crohn's Disease	D	D	D	D

REVIEW OF SYSTEMS (Symptoms you are experiencing today)

Allergic/Immunologic		
☐ None	Y	N
HIV exposure	☐	☐
Persistent infections	☐	☐
Strong allergic reactions or uticaria	☐	☐

Cardiovascular		
☐ None	Y	N
Chest pain	☐	☐
Very short of breath w/ normal exercise	☐	☐
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 bleed	☐	☐
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/incontinence	☐	☐

Hematological/Lymphatic		
☐ None	Y	N
Bleeding gums/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	☐	☐
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 w/ exercise	☐	☐
Wheezing	☐	☐

CONSENT TO SHARE DATA

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

☐ Yes ☐ No

REMINDER OF 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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Endoscopy Center of Red Bank

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