

PATIENT INSTRUCTIONS

1. Please complete and sign all paperwork. If your appointment is a week or more away, please mail the paperwork back to us. If your appointment is sooner, bring the paperwork with you at the time of your visit.
2. Please contact your primary care physician to have any lab work or testing done within the last year sent to our office prior to your appointment.
3. Please bring a list of all current medications you are taking.
4. Please bring your insurance card to your visit and a photo ID.
5. If your insurance company requires a referral, **you must have it at the time of your visit or you may need to reschedule your appointment or be responsible for full payment of all charges.**
6. **All copayments are due at the time of service or you may need to reschedule your appointment.**
7. Please arrive at our office at least 15 minutes prior to your appointment for registration purposes.
8. If you fail to show up for your appointment or do not give us at least 24 hours notice of cancellation, you will be charged \$75.00 for a new patient consultation visit and \$25.00 for follow up visits.

ALLIED GASTROINTESTINAL ASSOCIATES, P.A.

Patient Registration

PATIENT INFORMATION

Date _____

Last Name _____ First _____ Middle Initial _____

Address _____ City, State, Zip _____

Home Phone # _____ Work Phone # _____

Name & Phone # of Emergency Contact Person _____

Social Security # _____ Birth Date _____ Age _____

Gender Male Female Marital Status S M W D Smoker ? Yes No

Name of Spouse or Guardian _____

Were you referred here by a physician? Yes No If yes, please give his/her name & address

Do you have a family physician? Yes No If yes, please give his/her name & address

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? Yes No

If yes, please list _____

INSURANCE INFORMATION

Primary Carrier _____

Address _____

Identification/Policy # _____ Group # _____

Name & birth date of plan subscriber _____

Social Security # of subscriber _____

Does your primary insurance carrier require you to have a referral for medical services? Yes No

Does your primary insurance carrier require pre-certification for medical services? Yes No

Secondary Carrier _____

Address _____

Identification/Policy # _____ Group # _____

Name & birth date of plan subscriber _____

Social Security # of subscriber _____

Does your secondary insurance carrier require you to have a referral for medical services? Yes No

Does your secondary insurance carrier require pre-certification for medical services? Yes No

EMPLOYMENT INFORMATION

Name & address of your employer _____

Your occupation _____

ALL PATIENTS – PLEASE READ & SIGN

I hereby authorize ALLIED GASTROINTESTINAL ASSOCIATES, P.A. to keep this record of my signature on file for verification of treatment and as authorization to obtain any and all of my medical information which I may request be released. I also authorize ALLIED GASTROINTESTINAL ASSOCIATES, P.A. to keep this signature on file for any insurance benefits to be assigned to them.

Signature _____ Date _____

Medicare Patients – Please Read & Sign

I request that payment of authorized Medicare benefits be made on my behalf to ALLIED GASTROINTESTINAL ASSOCIATES, P.A. for any services furnished to me by ALLIED GASTROINTESTINAL ASSOCIATES, P.A. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Reviewed By

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

 Occupation

 Date

 Relationship to Patient

 Date



Allied Gastrointestinal Associates, P.A.
Diplomates, American Board of Internal Medicine
Diplomates, American Board of Gastroenterology

M. Arif Hashmi, M.D.
James L. Izanec, M.D.
John P. Kolnik, D.O.
Boris Libster, D.O.
Jay M. Malamut, M.D.
Vincent A. McLaughlin, M.D.
Verne M. Pineda, M.D.
Howard I. Siegel, M.D.
Brenda R. Velasco, M.D.

Authorization to Share Health Information

Emeritus
Dominic F. Comperatore, M.D.
Francis X. Keeley, M.D.

I, _____, allow my physician(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my treatment and/or condition.

This information can include spoken, written facts about my health or payment benefits that I may have. It can include copies of my records from healthcare providers or health plans about my health or care.

I authorize Allied Gastrointestinal Associates (AGA) to view any and all available RX History from an external source. I am aware that AGA uses a secure connection to SureScripts to send and receive most prescriptions in the office.

AGA will use and release this information only for treatment or payment for any and all services that they may render. AGA can also give this information to others as long as they remove any information that would identify me.

I understand that individuals that work for and with AGA may use and see my information, but they may only use it as specified on this form. I understand that AGA will keep my information private, but if it is accidentally given out, federal laws will not protect it.

This authorization will last seven (7) years after the date that I sign it. If at any time I want to change my mind and want to nullify this authorization, I will notify my healthcare providers and/or my insurer in writing that I do not want them to share any further information with outside entities. If I inform them to stop in writing, it will not change any actions they took before I informed them.

I am well aware that I do not have to sign this form. My choice about whether or not I sign this form will not alter the medical care or the way this practice treats me. I am aware that I have the right to see or obtain a copy of the information that the practice is sending to other providers and/or insurers.

I understand that it is my responsibility to obtain payment from my insurance company and that I am ultimately responsible for the costs of my care.

I agree that a copy of this form may be treated as a signed original.

Patient's Signature _____ Date _____



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In an effort to provide our patients with optimal medical care, we are requesting that as our patient, you take an active role in obtaining appropriate diagnostic studies that may have been performed before your scheduled appointment. These studies include blood work (laboratory studies), x-rays, MRI's, CT Scans, biopsy results (pathologic studies), and consultations and reports by other medical specialists.

Our experience has been that many of these studies that we request which would optimize your care in our office are not available to us at the time of your visit or consultation. The laboratory studies that we order are often sent to your primary care provider without being sent to our office. This situation has been made more difficult by privacy laws (HIPAA) which prevent physicians from sharing medical information without the written consent from the patient. Our patients are under the misconception that all of these studies are readily available to us because we are physicians. Unfortunately this is not the case.

We will continue to make reasonable efforts to obtain your reports before your appointment in our office but we ask the following:

- Do not assume that if you have not heard from our office that all of your studies are normal. We need for you to inquire about these studies in order to ensure that we have received your reports. Please schedule a follow up appointment to review any studies that you undergo after your appointment in our office.
- Please allow adequate time for us to retrieve your results. Please schedule the studies that we order in time for them to be analyzed and available for your appointment. If you schedule these studies a day before your appointment, do not be surprised that they are not available at the time of your appointment.
- If you have copies of your lab results or x-ray, MRI, or CT Scan reports, bring them with you. We will make copies and place them in your chart.
- Please follow the instructions regarding your laboratory and radiographic (x-rays) studies. Please pay attention to the timing of your endoscopic studies such as upper endoscopies and colonoscopies. If you have been advised to reschedule a procedure in several years, please contact our office at the appropriate time to schedule these studies. After years have passed, we may be unable to locate you to remind you to re-schedule such procedures.
- If you must cancel a procedure, be sure to reschedule at your earliest convenience.

We hope that these recommendations will improve the quality of your health care. Please feel free to discuss any questions with your physician in our office.

I acknowledge receiving this information.

Patient Signature

Date