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Robert I. Greenblatt, M.D.
Guida St. George, PA-C.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:

Gender at Birth: ___ Male ___ Female	Social Security Number: _______-_____-_______	Marital Status: __ Married __ Single __ Divorced __ Widowed	Date of Birth:

Race: __ African American ___ Hispanic __ American Indian ___ Asian __ Pacific Islander. ___ Caucasian ___Other: ___________________	Ethnic Group / Nationality	Primary Language: ___ English. ___ Español ___ Português. ___ Other

Home Address:	Apt #	City & State	Zip Code:

Home Ph #	Cell Ph #	Work Ph #

Primary Doctor & Telephone #:	Preferred Pharmacy Name, Location & Ph #
Cardiologist Name & Telephone #:	Who referred you to our practice?
Email Address:	

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
Under whose name is your insurance: ___Self ___ Other: ______________________	What is their date of birth?

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What is your relationship?	What is their social security number?

PATIENT CONFIDENTIALITY

Patient confidentiality is of great concern to our office. Please indicate below with whom our office may speak or leave a message with regarding your health, medication, test results, etc.

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

May we call you at work? ___ Yes ___ No

May we leave a voicemail? ___Yes ___ No

PATIENT AGREEMENT

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Advanced Gastroenterology Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature: ______________________________ Date: ___________________________

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PATIENT HISTORY FORM

Name: ____ Date: ______________________
Age: _______ Height: ________ Weight: _________ Referring Doctor: _____________________

I. MAIN COMPLAINT – THE MAIN REASON(S) YOU ARE SEEING THE DOCTOR TODAY:

___ Abnormal liver test
___ Painful Swallowing
___ Positive Stool Test
___ Weight Loss
___ Lower Abdominal pain
___ Difficulty Swallowing
___ Constipation
___ Bloating
___ Blood in stool
___ Fever
___ Upper abdominal pain
___ GERD/Heartburn/Indigestion
___ Diarrhea
___ Nausea
___ Changes in bowel habits
___ Hepatitis
___ Vomiting

II. OTHER SYMPTOMS YOU ARE HAVING: PLEASE CIRCLE YES OR NO

Bloating: yes / no
Diarrhea: yes / no
Nausea: yes / no
Blood in stool: yes / no
Fever: yes / no
Constipation: yes / no
Difficulty swallowing: yes / no
Painful swallowing: yes / no
Change in bowel habits: yes / no
Weight Loss: yes / no
Lower abdominal pain: yes / no
Upper abdominal pain: yes / no
Other: ____

What specific concerns or questions would you like the physician to address?

III. REVIEW OF SYSTEMS – IF YOU ARE CURRENTLY EXPERIENCING OR HAVE RECENTLY EXPERIENCED ANY: PLEASE CIRCLE YES OR NO

CONSTITUTIONAL
Fatigue: yes / no
Fever: yes / no
Appetite loss: yes / no
Weight loss: yes / no
Weight gain: yes / no
Other: _____________

CARDIOVASCULAR
Chest pain: yes / no
Edema: yes / no
Palpitations: yes / no
Short of breath: yes /no
Other: _______________

NEUROLOGICAL
Weakness: yes / no
Headaches: yes / no
Other: _____________

ENT
Bad breath: yes / no
Hoarseness: yes / no
Nose bleed: yes / no

GENITOURINARY
Frequent urination: yes / no
Painful urination: yes / no
Other: ___________________

PSYCHIATRIC
Anxiety Disorder: yes/ no
Depression: yes / no
Other: ________________

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Post nasal drip: yes / no
Sore throat: yes / no
Other: ________________

GYNECOLOGY
Chance of pregnancy: yes / no

ENDOCRINE
Dry skin: yes / no
Heat/Cold Intolerance: yes / no
Other: ___________________

RESPIRATORY
Cough: yes / no
Short of breath: yes / no
Wheezing: yes / no
Other: yes / no

MUSCULOSKELETAL
Back pain: yes / no
Joint pain: yes / no
Other: ____________

HEMATOLOGIC/LYMPHATIC
Anemia: yes / no
Bruise easily: yes / no
Tendency: yes / no
Enlarged lymph nodes: yes / no
Other: yes / no

IV: GENERAL MEDICAL HISTORY

Check if applicable

___ Arthritis
___ High Blood Pressure
___ Heart valve replacement
___ Lung Disease
___ Coronary Angioplasty (Balloon)
___Cardiac Catheterization
___ Renal Disease
___ Use of Blood Thinners
___ Heart Stents
___ Heart Attack

___ Diabetes
___ Dialysis
___Heart Murmur
___ Pacemaker
_____ Valve Surgery
___ Asthma
___ Use of home oxygen
-- Dates: ___________
-- Date(s): _________

___ Collagen Vascular Disease
___ Kidney Disease
___ Mitral Valve Prolapse
___ Defibrillator
___ Coronary Bypass Surgery
___ Stroke / epilepsy

V. GI PAST MEDICAL HISTORY: PLEASE CIRCLE YES OR NO

Have you ever had:

Colonoscopy: yes / no
Colon polyp(s): yes / no
Colon cancer: yes / no
GI bleed: yes / no
Ulcer disease: yes / no
Liver disease: yes / no
Irritable bowel syndrome: yes / no
Irritable bowel disease: yes / no
Ulcerative colitis: yes / no
Crohn's Disease: yes / no
GERD: yes / no
Pancreatitis: yes / no

VI: PAST SURGICAL HISTORY

Please list all operations you have undergone:

____
____
____
____
____

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VII: MEDICATIONS

Please list all your current medications:

Medications	Dosage	Frequency

VIII: ALLERGIES:

Have you ever experienced an adverse reaction (i.e.: low blood pressure / heart rate, difficulty breathing, etc.) to intravenous sedation or anesthesia? Yes ____. No _____

If yes, for what operation/procedure? ____

Date of procedure? ____

Please describe the reaction: ____

____

Please list any allergies, if known

Allergic to:	**Reaction:**

VIIII: RECREATIONAL USE:

Do you use alcohol? Yes / No Amount: _________________ Frequency: _______________
Do you use tobacco? Yes / No Packs per day: ___________ Frequency: _______________
Do you use marijuana? Yes / No Type: ___________________ Frequency: _______________
Do you vape? Yes / No Type: ___________________ Frequency: _______________
Do you use illicit drugs? Yes / No Type: ___________________ Frequency: _______________

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ADVANCED GASTROENTEROLOGY GROUP LLC

Patient Consent and Acknowledgement of Privacy Practices for Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

________________________, hereby states that by signing this Consent, agree and
(PATIENT'S NAME)

acknowledge the following:

1. The Notice of Privacy Practices ("Privacy Notice") for Advanced Gastroenterology Group, LLC, ("the Practice") has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the permissible uses and/or disclosures of my protected health information ("PHI") by the Practice. I understand that a copy of the Privacy Notice will be available to me in the future at my request. The Center has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Practice:

3. A postcard mailed to me at the address provided by me; and/or
    a. Telephoning my home and leaving a message on my answering machine.
    b. Telephoning my cellphone or leaving a text message.
    c. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

____
Signature of Patient or Legal Representative

____
Signature of Witness

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CANCELLATION POLICY / POLIZA DE CANCELACION

Dear Patients,

We strive to give our patients the utmost care and service.

Therefore, due to the limited amount of scheduling time at the hospitals and Garden State Endoscopy Center, we will charge a fee of $100 for any procedures, if not cancelled 3 business days prior to the appointment.

I understand and agree to the terms written above.

Print Name: ____

Date of Birth: ____

Date: ____

Signature: ____

ADVANCED GASTROENTEROLOGY GROUP

Thank you for choosing Advanced Gastroenterology Group for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

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Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment of care.
- If your insurance requires a referral, it is the patient's responsibility to obtain the referral and present at their office visit. **If a visit or procedure is denied due to no referral, the patient is responsible for payment.**
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patient are responsible for payment of co-pays, co-insurance, deductibles and all other procedure or treatment not covered by their insurance plan.
- **Co-pays are due at the time of service.**
- Co-insurance, deductibles and non-covered services are due 30 days from receipt of billing statement.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - **Returned Checks Charge - $20.00**
    - **No Show Fee - $50.00 for office visit and $100 for procedures**

We are aware that emergencies occur, however, it is your responsibility to notify our office 24-48 hours that you will not be able to keep your office or procedure appointment.

By my signature below, I hereby authorize assignment of financial benefits directly to Advanced Gastroenterology Group. I understand that I am financially responsible for all charges not covered by this assignment.

Patient Name: ____

Patient/Guardian Signature: ____

Date: ____

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Tracy Alves, DNP

PRACTICE INFORMATION & PATIENT/PHYSICIAN CONTRAST

Dear Patient,

Welcome to our practice specializing in gastroenterology and hepatology.

At the present time, our group consists of Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert G. Greenblatt, M.D. and Michel Margolin, M.D., all Board-Certified physicians in Internal Medicine and Gastroenterology. Our group also consists of Guida St. George, MS, PA-C and Tracy Alves, DNP.

Office hours will vary each day of the week and there may be variations in office hours during different seasons. Please inquire at our front desks for our current office hours. Overall, however, staff is present in the office between 9 A.M. and 5:00 P.M. on weekdays. The office is closed on weekends.

All our appointments are scheduled but provisions are always made for emergency walk-ins as the case becomes necessary.
The physicians in our practices are able to perform all of the gastroenterological-based procedures and may see a given patient at different times depending on availability.

Our practice is office based; however, we will also care for all our patients in the hospital regardless of whether we initiate the hospitalization, or other physicians do so and request that we also provide consultation care. The Garden State Endoscopy & Surgery Center is also a place of work for us, where many of our patients are evaluated and treated for the endoscopic procedures.

Hospital coverage is provided by members of our group and other associated physicians in the covered hospitals; they are also Board Certified in digestive diseases.

We are on staff at Trinitas Regional Medical Center, which is in Elizabeth, New jersey.
We always prefer that test results/information about other diagnostic results be discussed by us and the patient in person at our office.

It is a policy of our practice to fill prescriptions ONLY during regular office hours.

In the event that you must cancel an appointment, we ask that you please give us a 48-hour notice so that we can give that appointment to another patient that needs an appointment. Once you call to cancel, we can reschedule you at your convenience. **There will be a $50 charge for missed appointments that are not cancelled at least 24-hours prior to the appointed time.**

We take great pride in our reputation to provide the highest level of quality medical care to our patients. However, we realize that there are times that some patients will not be satisfied with the outcome of their treatment. We also must recognize that in these instances, the patient has every right to pursue legal action if he or she feels that we have been negligent in some way. We respect every patient's right to do so.

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While some health care legal claims are justified, there are also frivolous legal claims filed in our country – claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of Board-Certified Experts will help expedite resolutions of concern.

OUR COMMITMENT TO YOU

WE COMMIT TO USING ONLY AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) BOARD CERTIFIED EXPERT MEDICAL WITNESSES IN ANY LEGAL SITUATION WHO FOLLOW THE CODE OF ETHICS OF OUR NATIONAL SPECIALTY SOCIETY. THESE STEPS ENSURE THAT EXPERT MEDICAL WITNESSES WE USE HAVE PASSED EXAMINATIONS AND DEMONSTRATE EXPERTISE IN THEIR FIELD AND ADHERE TO A SOLID CODE OF ETHICS AND WE WILL DEMONSTRATE THIS COMMITMENT TO YOU WITH OUR SIGNATURE ON THIS FORM.
WHAT WE ARE ASKING YOU TO DO – WE ARE ASKING YOU OR ANY REPRESENTATIVE TO COMMIT TO THIS PROCESS ALSO BY USING ONLY BOARD-CERTIFIED PHYSICIANS AND EXPERT MEDICAL WITNESSES IF YOU ARE DISSATISFIED WITH YOUR MEDICAL CARE AND DECIDE ON LEGAL ACTION.
WE HOPE AND BELIEVE THAT YOU WILL NEVER HAVE TO CONSIDER THIS AGAIN, BUT IF YOU DO, WE WILL HONOR THIS COMMITMENT TO YOU.

PATIENT/PHYSICIAN AGREEMENT

I understand that I am entering into a contractual relationship with Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert Greenblatt, M.D., Guida St. George, MS, PA-C and Tracey Avles, DNP for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and the validity of medical care and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert Greenblatt, M.D., Michael Margolin, M.D., Guida St. George, MS, PA-C and Tracey Alves, DNP. I ________________________________ and/or my representative agree not to advance directly or indirectly any face meritless and/or frivolous claims of medical malpractice against Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Michael Margolin, M.D., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert Greenblatt, M.D. Guida St. George, MS, PA-C and Tracey Alves, DNP. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (-_____________________________) and/or my representative agree to use ABMS Board Certified Expert Medical Witnesses in the same specialty as Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert Greenblatt, M.D., Michael Margolin, M.D., Guida St. George, MS, PA-C and Tracey Alves, DNP. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the Specialty Societies for Expert Witnesses in the areas of medicine that would typically have the background and experienced opinion on such a case. In further consideration for this, we, Patrick G. Tempera, M.D., Rajesh Dhirmalani, D.O., Kunal Grover, M.D., Michael J. Viksjo, M.D., Prakriti S. Merchant, M.D., Arun R. Mathew, M.D., Daniel Bodek, M.D., Robert Greenblatt, M.D., Michael Margolin, M.D., Guida St. George, MS, PA-C and Tracey Alves, DNP, agree to the same stipulations.

____ ____

PHYSICIAN SIGNATURE DATE

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