

Advanced Gastroenterology Associates, LLC

Providing leading-edge care with compassion

BOARD CERTIFIED IN INTERNAL MEDICINE AND GASTROENTEROLOGY

Patient Registration Form

***Name:** _____
Last First Middle Initial

***Social Security #:** _____ Sex: _____ Age: _____

***Date of Birth:** _____ ***Primary Language:** _____

***Local Address:** _____

***City, State, Zip Code:** _____

***Ethnicity:** Hispanic or Latin / Non-Hispanic or Latin / Refused to Report

***Race:** American Indian or Alaska Native / Asian / Native Hawaiian or other Pacific / Black or African American / White / Hispanic / Other

***Home Phone #:** _____ **Cell Phone #:** _____

E-mail: _____

If not a FT FL Resident, in what state are you a legal Resident? _____

If you only live in FL in the winter, what months of the year are you here?

Out of State Address & Phone # (if applicable)

***Pharmacy Name:** _____

Address: _____

Phone: _____ Fax: _____

***Emergency Contact Information:** Name: _____

Relationship: _____ Phone #: _____

Primary Care Physician: _____ **Phone:** _____

Sanjiv P. Amin, DO
Jawahar L. Taunk, MD
Michael P. Zelig, MD
Corporate Office
34041 US Hwy 19N
Suite A
Palm Harbor, FL 34684
727-786-0017
727-786-7521 - Fax

Tiyyagura S. Reddy, MD
7614 Jacque Road
Suite B
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727-863-2105
727-862-2512 - Fax

L. Venu, MD
(Venu Lakshminarasimhan)
7533 Medical Drive
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Name: _____ **Age:** _____

How did you hear about us: _____?

Do you have a primary care physician: No/ Yes

Dr. _____ Phone Number: _____

Reason for today's visit: _____

Allergies: Penicillin/Sulfa/Codeine/Latex/Adhesive Tape/Other:

List all medications you are currently taking: (use back if needed)

On the following pages, please circle the appropriate words, Yes or No, or fill in the blanks as indicated. Thank you.

YOUR Medical History:

Have YOU ever had any of the following? (Circle all that apply)

Ulcers, hiatal hernia, Barrett's esophagus, esophageal stricture/ring, esophageal varices, Helicobacter pylori

Colon polyps, colon cancer, irritable bowel syndrome, Crohn's disease, ulcerative colitis, diverticulosis, hemorrhoids, fistula, anal fissure.

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Name: _____

Hepatitis, cirrhosis, gallstones, pancreatitis.

High Cholesterol, high blood pressure, angina, heart attack, heart murmur, endocarditis, atrial fibrillation, irregular heart rhythm.

COPD/emphysema, asthma, **Tuberculosis or Tuberculosis exposure.**

Diabetes, hypothyroidism, osteoporosis, osteopenia, **HIV/Aids**

Stroke, TIA, migraines.

Arthritis, chronic back pain, fibromyalgia.

Depression, anxiety, bipolar disorder.

Other cancers: skin, breast, uterine, ovarian, prostate

Have YOU had any of the following surgery?

Appendectomy, colectomy (partial, right, left, or sigmoid), small bowel resection, hemorrhoidectomy, colostomy, ileostomy, hiatal hernia surgery, gastric bypass/stapling weight loss surgery, ulcer surgery, gallbladder, umbilical hernia repair, inguinal hernia repair (right, left, both), tonsillectomy, hysterectomy, tubal ligation, coronary artery bypass, C-Section(s) (#? ___), mastectomy, prostate surgery, Knee surgery, hip surgery, shoulder surgery, carpal tunnel release, implanted defibrillator (Medtronic, Guidant, Other), pacemaker, heart valve replacement (Aortic, mitral, not known).

Have you ever had an upper endoscopy: Yes No Date: _____

Have you ever had your esophagus dilated? Yes No Date: _____

Have you ever had a colonoscopy? Yes No Date: _____

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Name: _____

YOUR Family History:

Has a **blood relative** (not yourself or spouse) had the following (circle)?

Colon and/or rectal cancer? Who/age? _____

Esophageal cancer? Who/age? _____

Stomach cancer? Who/age? _____

Liver cancer? Who/age? _____

Pancreatic cancer? Who/age? _____

Colon polyps? Who/age? _____

Cancer of: breast, uterus, ovaries.

Liver disease? Who? _____ Alcohol related? Yes No

Ulcerative Colitis? Who? _____

Crohn's disease? Who? _____

Personal History – YOU MUST ANSWER ALL QUESTIONS

Do you smoke? Yes No How long? _____ Packs per day? ____

Pipe? Cigars? Chew tobacco?

Ex-smoker? When did you quit? _____

Have you ever used heroin/cocaine/marijuana/ methamphetamine? Yes No

Intravenously? Yes No

Have you had a blood transfusion? Yes No Year? _____

Do you have tattoos? Yes No Do you have body piercings? Yes No

Alcohol use: Never / social / rarely / daily / heavily.

Beer? Liquor? Wine? _____ times per week/day/month/year.

Ever drink heavily? Yes No

Married/ Significant Other/Divorced/Separated/Widowed

How many children? _____

Occupation: _____? Retired? Yes No

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Name: _____

REVIEW OF SYSTEMS

Do **YOU currently** have any of the following? (Please circle only those that apply):

General: Change in appetite, fatigue, fever, weight loss

Allergic: Food sensitivities (shellfish/milk products/nuts/gluten/other)

Animal sensitivities (cats/dogs/other)

Insect sensitivities (bees, wasps, spiders, fire ants, other)

Eyes: Blurred vision, eye pain, red eyes

ENT: Dry mouth, ear pain, nosebleeds

Endocrine: Cold intolerance, excessive sweating, excessive thirst, heat intolerance, weakness

Respiratory: Cough, hemoptysis, sputum production, wheezing.

Heart: Chest pain at rest, dizziness, palpitations, shortness of breath

Hematologic: Anemia, easy bruising, fever, groin mass

Genitourinary: Blood in urine, difficulty urinating, frequent urination, painful urination

Musculoskeletal: Arthritis, leg cramps, muscle aches, back pain

Skin: Blistering skin, eczema, itching, rash

Neurological: Dizziness, stroke, seizures, tremor.

Psychiatric: Anxiety, depressed mood, eating disorder, suicidal thoughts.

Females only:

Do you have excessive bleeding with period? Yes No

Menopause occurred at age: _____

Number of pregnancies: _____

Number of children: _____

Breast lumps? Yes No

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Current Gastrointestinal/Liver Problems:

(Please circle any problem **YOU** are having at the *present* time)

Excessive Salivation

Acid Regurgitation/Sour taste / Heartburn

Food sticks when swallowing

Belching

Nausea / Vomiting / Vomiting blood

Pain above the belly button

Pain below the belly button

Gas from below

Change in bowel habits / Constipation / Diarrhea

Black stool / Bloody stool / Blood with wiping only

Anal or rectal pain

Leakage of stool/soiling

Jaundice/Yellow skin or eyes

Hepatitis

Please add any other remarks you feel will help us better understand why you are here today:

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Required Signatures

Insurance Statement (All Insurances):

I request that payment of authorized insurance benefits be made on my behalf to Advanced Gastroenterology Associates, LLC for any services furnished. I authorize any holder of medical information about me be released to the insurance carrier/Health Care Finance Administration and it's agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Advanced Gastroenterology Associates, LLC. I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and it's agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing this authorization will allow Medicare payment information to cross-over automatically.

All Patients (Required):

I understand that as a courtesy Advanced Gastroenterology Associates, LLC will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the Pinellas County court.

Rx History Consent:

I hereby give you permission to view my prescription information and history from all external sources. By signing this consent form you are agreeing that AGA, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for all treatment purposes.

Understanding all of the above, I hereby provide informed consent to Advanced Gastroenterology Associates, LLC.

Patient's Signature/Representative

Date

Print Name

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Notice of Privacy Practices

Acknowledgement:

I have read the copy of the Advanced Gastroenterology Associates, LLC Notice of Privacy Practices.

Date: _____

Print Name: _____

I understand my medical information and reports will be automatically sent to my primary care physician. **I authorize additional release of my medical information and records to the following:**

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Understanding all of the above, I hereby provide informed consent to Advanced Gastroenterology Associates, LLC.

Patient's Signature: _____

Guardian's Signature: _____

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