# Advanced Gastroenterology Associates, LLC

*Providing leading-edge care with compassion*

***BOARD CERTIFIED IN INTERNAL MEDICINE AND GASTROENTEROLOGY***


*Sanjiv P. Amin, DO*
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*34041 US Hwy 19N*
*Suite A*
*Palm Harbor, FL 34684*
*727-786-0017*
*727-786-7521 - Fax*

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*(Venu Lakshminarasimhan)*
*7533 Medical Drive*
*Hudson, FL 34667*
*727-862-9436*
*727-862-5611 - Fax*

*advancedgastro.com*


## 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: _____

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***__Emergency Contact Information:__** Name: _____

Relationship: _____ Phone #: _____

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

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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, including vitamins: (attach list if possible)

| **Medication/Vitamin:** | **Reason for taking:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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**Name: _____**

## ***YOUR* Medical History:**

## Have *YOU* ever had any of the following? (*Check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| Ulcers | | Cirrhosis | | Hypothyroidism | |
| Hiatal Hernia | | Gallstones | | Osteoporosis | |
| Barrett's Esophagus | | Pancreatitis | | Osteopenia | |
| Esophageal Stricture/ring | | Hypercholesterolemia | | **HIV\Aids** | |
| Esophageal Varices | | Hypertension | | CVA (Stroke) | |
| Helicobacter Pylori | | Angina | | TIA | |
| Colon Polyps | | Old MI (Heart Attack) | | Migraines | |
| Colon Cancer | | Heart Murmur | | Arthritis | |
| Irritable Bowel Syndrome | | Endocarditis | | Chronic Back Pain | |
| Crohn's Disease | | Atrial Fibrillation | | Fibromyalgia | |
| Ulcerative Colitis | | Irregular Heart Rhythm | | Depression | |
| Diverticulosis | | Valvular Heart Disease | | Anxiety | |
| Hemorrhoids | | COPD\Emphysema | | Bipolar Disorder | |
| Fistula | | Asthma | | **Other Cancers:** | |
| Anal Fissure | | **Tuberculosis or Tuberculosis Exposure** | | Skin, Breast, Uterine, Prostate, Ovarian | |
| **Hepatitis (Type___)** | | Diabetes (Type___) | | Year Diagnosed: | |

**Other medical conditions not listed:** _____

_____

_____

_____

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**Name: _____**

**Have *YOU* had any of the following surgery? *(Check all that apply)***

| | | | | | |
|---|---|---|---|---|---|
| Appendectomy | | Umbilical Hernia Repair | | Carpal Tunnel Release | |
| Colon/Small Bowel Resection | | Ulcer Surgery | | Shoulder Surgery | |
| Hemorrhoidectomy | | Tonsillectomy | | Back/Disc Surgery | |
| Colostomy | | Coronary Artery Bypass | | Joint Replacement (Type_____) | |
| Ileostomy | | Pacemaker | | Prostate Surgery | |
| Hiatal Hernia Surgery | | Coronary Stent Placement | | Tubal Ligation | |
| Gallbladder | | Arterial Stents | | Hysterectomy | |
| Weight Loss Surgery (Type_____) | | Heart Valve Replacement (Aortic, Mitral, Unknown) | | Cesarean Section(s) (Number_____) | |
| Inguinal Hernia Repair (Right, Left, or Both) | | Implanted Defibrillator (Medtronic, Guidant, Other) | | Mastectomy (Right, Left, or Both) | |

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: _____

**Other surgeries not listed:** _____

_____

**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 | Who: | Age: |
| Ulcerative Colitis | Who: | Age: |
| Crohn's Disease | Who: | Age: |
| Liver Disease<br>**Alcohol related? Yes or No** | Who: | Age: |
| Hypertension | Who: | Age: |
| Heart Disease | Who: | Age: |

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**Name: _____**

**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
If yes, how long ago? _____

Have you had a flu shot this year? Yes No
When? _____

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 / rarely / socially / daily / heavily (Circle One)
Beer? Liquor? Wine? (Circle One) _____ drinks per week/day/month/year.
**Ever drink heavily**? Yes No

Married/ Significant Other/Single/Divorced/Separated/Widowed
How many children? _____
Occupation: _____? Retired? Yes No

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**Name: _____**

## REVIEW OF SYSTEMS

Do **YOU <u>currently</u>** 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.

**<u>Females only</u>**:

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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**Name: _____**

**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

Abdominal bloating

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

Weight Loss

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**: _____