DIGESTIVE HEALTHCARE CENTER

511 Courtyard Drive • Bldg 500
Hillsborough, NJ 08844

412 Courtyard Drive • Bldg 400
Hillsborough, NJ 08844

319 East Main St
Somerville, NJ 08876

31 Mountain Blvd • Suite H
Warren, NJ 07059

Tel (908) 218-9222
Fax (908) 218-9818
www. DHCCENTER.com

PATIENT INFORMATION

PERSONAL INFORMATION

Marital Status: (Circle one) Single Married Divorced Widowed Other

Last Name_____ First Name_____ Middle Name_____

Date of Birth_____ SS#_____ MALE_____ FEMALE_____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Mobile #_____ Home #_____ Work #_____

Employer Name & Address_____

Employer Phone #_____ Your Occupation_____

INSURANCE INFORMATION

SELF PAY (NO INSURANCE) ☐ (check box if applicable)

PRIMARY Insurance Company Name _____ ID # _____ Group # _____

Policyholder Name _____ Policyholder Date of Birth _____

Relationship to Policyholder: (circle one) SELF SPOUSE CHILD LIFE PARTNER OTHER _____

SECONDARY Insurance Company Name _____ ID # _____ Group # _____

Policyholder Name _____ Policyholder Date of Birth _____

Relationship to Policyholder: (circle one) SELF SPOUSE CHILD LIFE PARTNER OTHER _____

EMERGENCY CONTACT (IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT ON YOUR BEHALF?)

Name_____ Relationship _____

Address_____

Mobile #_____ Home #_____ Work #_____

Did a friend or relative refer you to Digestive Healthcare Center? If so, may we have their name? _____

DIGESTIVE HEALTHCARE CENTER

Financial Policy

If you have insurance coverage, we will file claims on your behalf. Patients are responsible for their co-payments at the time of visit. Payments may be made by cash, check, money order, Visa, or MasterCard.
Regarding Insurance companies with which we participate: You are responsible to supply our staff with your primary and secondary, if any, insurance card(s) at the time of your appointment. If your insurance company requires a referral from your primary care physician, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. It is the patient's responsibility to obtain any referrals. If you do not obtain a referral when your insurance company requires one, **you will be required to pay in full for the visit or service.**
Should your claim be denied, or omitted/inaccurate insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party.
Regarding Late Cancelations/No Show Appointments: Patients must give us 24 Hours notice prior to cancelling or rescheduling their appointment. DHC may charge $50 for No show/Late cancel/Late reschedule. This applies to both telehealth and in-person office appointments.
Regarding Patient Deductibles, Co-insurance, and/or Copays: Payment for known copays, co-insurance, and deductibles are the patient's responsibility to know and understand. After insurance claims are paid, the remaining balances on your account are your responsibility to be paid in full, within the regularly scheduled billing cycle of 30 days unless payment arrangements are made with our billing department. It is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, i.e., if the practice is not part of your insurance's network, we will notify you prior to your procedure.
Regarding Non-Participating Insurances: If we do not participate with your insurance, the bill is your responsibility. We accept cash, check, money order, Visa, and MasterCard. Your policy is a contract between you and your insurance company. Our office is not part of that contract. **Currently, this includes all managed Medicaid plans except Amerigroup and NJ Health.**
For patients without insurance: You are required to pay for services at the time of your visit. If you are scheduled for a procedure, we will go over the costs at the time your procedure is scheduled. A deposit equal to 50% is required on the day of your procedure.
If you do not have health insurance through a job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or another source that provides qualifying coverage, the Marketplace can help get you covered. Just log on to www.obamacareplans.com or call 855-480-9344.

**** There will be a $100.00 charge for cancelled procedures scheduled at Robert Wood Johnson University Hospital unless 48-hour notice is given****

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, you must inform us before you see the doctor.
I have read the above financial policy. I understand and agree to abide by its terms.

Patient Signature: _____ **Date:** _____

Print Patient Name: _____

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____ Age: _____

Email

Personal: _____

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Unknown
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to specify
- ☐ Prohibited by state law
- ☐ Unknown

Sex

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Unknown

Preferred Language

- ☐ English
- ☐ Italian
- ☐ Spanish; Castilian
- ☐ Patient declines to specify

Contact Preference

- ☐ Letter
- ☐ Patient portal
- ☐ Any of the Above
- ☐ Patient declines to specify

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies

- ☐ Codeine
- ☐ Penicillins
- ☐ Erythromycin
- ☐ Iodine
- ☐ Sulfa
- ☐ Aspirin
- ☐ Morphine
- ☐ Demerol
- ☐ Versed
- ☐ Novocain
- ☐ Propofol
- ☐ IV contrast
- ☐ Soy products
- ☐ Latex
- ☐ Tape

Other: _____

Immunizations

- ◯ None
- ◯ Hep B — When: _____
- ◯ Hep A — When: _____
- ◯ Influenza, seasonal, injectable — When: _____
- ◯ Pneumococcal conjugate PCV 13 — When: _____
- ◯ Screened for Hepatitis C — When: _____
- ◯ COVID vaccine — When: _____

Past or Present Medical Conditions

- ◯ None
- ◯ Abnormal bleeding tendencies
- ◯ Anemia
- ◯ Antibiotics required before dental work
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Blood clots
- ◯ Breast cancer
- ◯ Chest pain
- ◯ C.O.P.D.
- ◯ Cirrhosis
- ◯ Colitis
- ◯ Colon cancer
- ◯ Colon polyps
- ◯ Congestive Heart Failure
- ◯ Crohn's Disease
- ◯ Depression
- ◯ Diabetes Mellitus
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Duodenal Ulcer
- ◯ Fatty Liver
- ◯ Frequent Urinary Tract Infections
- ◯ Gallstones
- ◯ Heart Attack-MI
- ◯ Heart Murmurs
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hiatal hernia
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ High tryglycerides
- ◯ HIV/AIDS
- ◯ Irregular heart beat
- ◯ Irritable bowel syndrome
- ◯ Kidney disease
- ◯ Kidney failure
- ◯ kidney stones
- ◯ Lactose Intolerance
- ◯ Migraines
- ◯ Osteoarthritis
- ◯ Palpitations
- ◯ Pancreatitis
- ◯ Paralysis
- ◯ Parkinsons
- ◯ Peptic ulcer disease
- ◯ Pneumonia
- ◯ Problems with anesthesia
- ◯ Reflux
- ◯ Rheumatic Fever
- ◯ Rheumatoid arthritis
- ◯ Seizures
- ◯ Shortness of breath
- ◯ Skin Cancer
- ◯ Sleep apnea
- ◯ Stomach ulcer
- ◯ Stroke
- ◯ TB (tuberculosis)
- ◯ TB skin test positive
- ◯ Thyroid disease
- ◯ Ulcerative colitis
- ◯ Urinary disorder
- ◯ Ovarian Cancer
- ◯ Uterine cancer
- ◯ Pancreatic cancer

Other: _____

Previous Procedures

- ◯ None
- ◯ Appendectomy
- ◯ Breast surgery
- ◯ C-Section
- ◯ Cardiac surgery
- ◯ Colon Resection
- ◯ Colonoscopy
- ◯ Defibrillator
- ◯ EGD/Upper endoscopy
- ◯ ERCP
- ◯ Gallbladder
- ◯ Heart bypass surgery
- ◯ Heart stent
- ◯ Heart valve replacement
- ◯ Hemorrhoids
- ◯ Hiatal hernia
- ◯ Hysterectomy
- ◯ Joint surgery-replacement
- ◯ Kidney
- ◯ Liver
- ◯ Liver biopsy
- ◯ Obesity surgery
- ◯ Pacemaker
- ◯ Prostate
- ◯ Sigmoidoscopy
- ◯ Stomach
- ◯ Thyroid
- ◯ Tonsillectomy
- ◯ Transplant surgery
- ◯ Tubal Ligation
- ◯ Vasectomy

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other

Alcohol

- ☐ None
- ☐ Daily
- ☐ More than 2 days/week
- ☐ Less than 2 days/week
- ☐ Rarely
- ☐ I quit using alcohol

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

- ☐ Cigar
- ☐ Smokeless
- ☐ Chewing Tobacco
- ☐ Cigarettes

Drug Use

- ☐ None
- ☐ I quit using illicit drugs.
- ☐ I have never used illicit drugs
- ☐ I use illicit drugs
- ☐ Injection drug use

Exercise

- ☐ None
- ☐ Light
- ☐ Moderate
- ☐ Strenuous

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

	Mother	Father	Brother	Sister	Grandmother	Grandfather	Daughter	Son
Diagnoses								
Alcohol use, excessive	○	○	○	○	○	○	○	○
Breast cancer	○	○	○	○	○	○	○	○
Breast cancer diagnosed at age 50 or younger	○	○	○	○	○	○	○	○
Bleeding problems	○	○	○	○	○	○	○	○
Colitis	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○
Colon cancer diagnosed at age 50 or younger	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○
Gall Bladder Disease	○	○	○	○	○	○	○	○
Heart Trouble	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○

Ulcer Disease ○ ○ ○ ○ ○ ○ ○ ○

Ulcerative Colitis ○ ○ ○ ○ ○ ○ ○ ○

Uterine Cancer ○ ○ ○ ○ ○ ○ ○ ○

Uterine Cancer diagnosed at age 50 or younger ○ ○ ○ ○ ○ ○ ○ ○

Other: ○ ○ ○ ○ ○ ○ ○ ○

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No

Consent to Share Data

In the event that we refer you to another health care provider, may we send them your medical records?

○ Yes ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

○ Yes ○ No

Signature

Signature Date

MEDICATION RECONCILIATION/ALLERGY FORM

PATIENT NAME:_____ DOB:_____
PHARMACY NAME:_____ LOCATION:_____ PHONE#_____
ALLERGIES: (SEE BELOW) MEDICATION: Y N FOOD (INCLUDING EGGS OR SOY) Y N LATEX Y N

MEDICATION/REACTION	MEDICATION/REACTION

(List all medications, OTC drugs, Herbal supplements) **Write NONE if no meds are taken**

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)	Start Date
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o		o		
o BLOOD THINNERS (DENIES)		o		
o		o		
o		o		

ATTESTATION: The above is a complete and accurate medication list to the best of my knowledge. It includes over the counter and herbal supplements, as well as regular and occasionally used prescription drugs. Your physician is resuming the start of your medication on the information provided by you, including the name of the medications, dosages and frequency.

Patient/Guardian Signature:_____ Date:_____

Nursing Use Only: Source: ___Patient ___Family ___List
Obtained By: Pre-OP RN Signature:_____ Date:_____
Anesthesiologist_____ Date:_____
OR RN Signature:_____ Date:_____

You may safely resume taking all of the above medications after your procedure, including over the counter medications and dietary supplements prescribed by your physician. EXCEPTIONS SEE BELOW:

Medication Dosage/Frequency	Resume Medication Date/Time

New Medication Prescribed Following Your Procedure

Medication	Dosage/Route/Frequency	Next dose

PACU RN Signature:_____ Physician Signature:_____

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HIPAA
Confidential Communication Form

I, _____ gives Digestive Healthcare Center, PA permission to release and discuss my medical condition, treatment, and results with the persons and physicians listed below:

A. Friends and/or Family

Name_____ Date of Birth_____ Relationship_____

Name_____ Date of Birth_____ Relationship_____

Name_____ Date of Birth_____ Relationship_____

OR

I DO NOT GIVE DIGESTIVE HEALTHCARE CENTER PERMISSION TO RELEASE AND/OR DISCUSS MY MEDICAL CONDITION, TREATMENT, AND RESULTS WITH ANYONE. ☐ Check box if applicable

PLEASE NOTE: If you CHECK THE BOX above, we cannot release any information (verbal or written) to ANYONE.

B. Physicians

Name_____ Address_____ Phone # _____

Name_____ Address_____ Phone # _____

Name_____ Address_____ Phone # _____

Communications: Please indicate how you wish us to reach you.

1st Preference ( ) _____ Home Cell Work OK to leave a detailed message? YES or NO
PLEASE CIRCLE ONE

2nd Preference ( ) _____ Home Cell Work OK to leave a detailed message? YES or NO
PLEASE CIRCLE ONE

Email Address: Is it ok to contact you via email, if so please provide email address below:

_____ By providing us with your email address, you will receive an invitation to our PATIENT PORTAL which will permit you to manage your personal medical records, communicate with our doctors and make more informed decisions about your health.

This release of information form will be in effect until notified of the contrary. If you want this form to expire on a particular date, indicate here. Expiration Date: _____

Print Name_____ Date of Birth_____

Signature_____ Date_____

KS 10/19/16
conf. com. form

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HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT

You may request a personal copy for your records.

There is a copy posted at the front desk.

I, _____, have been provided with an opportunity to review Digestive Healthcare Center's Hipaa Privacy Practices and have been offered a copy for my records.

Signature_____ Date_____