



511 Courtyard Drive • Bldg 500  
Hillsborough, NJ 08844

319 East Main St  
Somerville, NJ 08876

412 Courtyard Drive • Bldg 400  
Hillsborough, NJ 08844

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: Single Married Divorced Widowed Other  
(Circle one)

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? \_\_\_\_\_

**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 Cancellations/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.

**Return check Fee:** The patient will be charged **\$15.00** return check bank fee along with their balance.

**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 for 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](http://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

- |                                  |   |   |  |   |
|----------------------------------|---|---|--|---|
| <input type="radio"/> White      | <input type="radio"/> Black or African American | <input type="radio"/> Asian                       | <input type="radio"/> American Indian or Alaska Native | <input type="radio"/> Native Hawaiian or Other Pacific Islander |
| <input type="radio"/> Other Race | <input type="radio"/> Unknown                   | <input type="radio"/> Patient declines to specify | <input type="radio"/> Prohibited by state law          |   |

#### Ethnicity

- |  |  |   |   |                               |
|--|--|---|---|-------------------------------|
| <input type="radio"/> Hispanic or Latino | <input type="radio"/> Not Hispanic or Latino | <input type="radio"/> Patient declines to specify | <input type="radio"/> Prohibited by state law | <input type="radio"/> Unknown |
|--|--|---|---|-------------------------------|

#### Sex

- |                            |                              |                             |                               |
|----------------------------|------------------------------|-----------------------------|-------------------------------|
| <input type="radio"/> Male | <input type="radio"/> Female | <input type="radio"/> Other | <input type="radio"/> Unknown |
|----------------------------|------------------------------|-----------------------------|-------------------------------|

#### Preferred Language

- |                               |                               |  |   |
|-------------------------------|-------------------------------|--|---|
| <input type="radio"/> English | <input type="radio"/> Italian | <input type="radio"/> Spanish; Castilian | <input type="radio"/> Patient declines to specify |
|-------------------------------|-------------------------------|--|---|

#### Contact Preference

- |                              |                                      |  |   |
|------------------------------|--------------------------------------|--|---|
| <input type="radio"/> Letter | <input type="radio"/> Patient portal | <input type="radio"/> Any of the Above | <input type="radio"/> Patient declines to specify |
|------------------------------|--------------------------------------|--|---|

### Allergies

- |  |   |                                    |                              |                                |
|--|---|------------------------------------|------------------------------|--------------------------------|
| <input type="radio"/> Patient has no known allergies | <input type="radio"/> Patient has no known drug allergies |                                    |                              |                                |
| <input type="radio"/> Codeine                        | <input type="radio"/> Penicillins                         | <input type="radio"/> Erythromycin | <input type="radio"/> Iodine | <input type="radio"/> Sulfa    |
| <input type="radio"/> Aspirin                        | <input type="radio"/> Morphine                            | <input type="radio"/> Demerol      | <input type="radio"/> Versed | <input type="radio"/> Novocain |
| <input type="radio"/> Propofol                       | <input type="radio"/> IV contrast                         | <input type="radio"/> Soy products | <input type="radio"/> Latex  | <input type="radio"/> Tape     |

Other: \_\_\_\_\_

## Immunizations

☐ None  
☐ Hep B      ☐ Hep A      ☐ Influenza, seasonal, injectable      ☐ Pneumococcal conjugate PCV 13      ☐ Screened for Hepatitis C  
 When: \_\_\_\_\_ When: \_\_\_\_\_      When: \_\_\_\_\_      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



☐ No knowledge of family history

No family history of ☐ Colon cancer

 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 \_\_\_\_\_ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 7

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 or FOOD/REACTION	MEDICATION or FOOD/REACTION

(List **ALL** medications, OTC drugs, Herbal supplements) **EVEN IF YOU HAVE NOT TAKEN THEM TODAY**

Medication (RN check if taken today)	Dose/Frequency	Unknown	Indication (Reason)	Start Date
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/> BLOOD THINNERS (DENIES)		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		
<input type="radio"/>		<input type="radio"/>		

**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:** \_\_\_\_\_





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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.

1 <sup>st</sup> Preference ( ) _____	Home Cell Work OK to leave a detailed message? YES or NO
	PLEASE CIRCLE ONE
2 <sup>nd</sup> 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 \_\_\_\_\_



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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 \_\_\_\_\_