



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? _____



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 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 |
| ☐ Middle Eastern or North African (MENA) | ☐ 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 |
| ☐ Aspirin | ☐ Morphine |
| ☐ Propofol | ☐ IV contrast |
| ☐ Erythromycin | ☐ Iodine |
| ☐ Demerol | ☐ Versed |
| ☐ Soy products | ☐ Latex |
| ☐ Sulfa | ☐ Novocain |
| ☐ Tape | |

Other: _____

Immunizations

☐ None

☐ Hep B

☐ Hep A

☐ Influenza,
seasonal,
injectable

☐ Pneumococcal
conjugate PCV 13

☐ Screened for
Hepatitis C

When: _____ 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 triglycerides

☐ 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

☐ Breast surgery

☐ C-Section

☐ Cardiac surgery

☐ Colon Resection

☐ Appendectomy

☐ 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

☐ Tubal Ligation

☐ Stomach

☐ Thyroid

☐ Tonsillectomy

☐ Transplant surgery

☐ Vasectomy

Other: _____

Colorectal Cancer Screening Procedures

☐ Colonoscopy

☐ Flexible Sigmoidoscopy

☐ FIT-DNA/Cologuard

☐ CT Colonography/
Virtual Colonoscopy

☐ FOBT (rectal exam)

When? _____

When? _____

When? _____

When? _____

When? _____

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 |

Caffeine

- ☐ None

Intake: _____

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 |
| | | | ☐ Vaping |

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 _____ Date _____



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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
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐		☐		
☐ BLOOD THINNERS (DENIES)		☐		
☐		☐		
☐		☐		

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



You have the right to have an observer in the exam room during breast, pelvic, genital, and rectal exams with any doctor. An observer is a person trained to know what to expect and watch a doctor during these exams. The observer can help make sure you are not touched inappropriately. If you want an observer, ask for one. And remember, you can stop the exam at any time for any reason.

If your doctor does not provide an observer, or if you are not comfortable with the observer that is offered, you can postpone or cancel your exam. If that happens, your doctor must provide you with a referral to another health care provider, if available. You can also decide to go ahead with the exam without an observer or go ahead with the other parts of your doctor's visit that don't include the exam. It is your decision.

The New Jersey Division of Consumer Affairs licenses doctors and other health care providers. **If you have any concerns or complaints about your exam, you can file a complaint with the Division of Consumer Affairs. More information about filing a complaint is available at <https://www.njconsumeraffairs.gov/sexual-misconduct-complaint>.**

Patient Name: _____

Patient Signature: _____

Today's Date: ____/____/____

Patient Date of Birth: ____/____/____