

# 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  
Mirela Onea, 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  
Hudson, FL 34667  
727-863-2105  
727-862-2512 - Fax

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

advancedgastro.com



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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		<b>HIV\Aids</b>	
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		<b>Other Cancers:</b>	
Anal Fissure		<b>Tuberculosis or Tuberculosis Exposure</b>		Skin, Breast, Uterine, Prostate, Ovarian	
<b>Hepatitis (Type___)</b>		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:
<b>Cancer of:</b> Breast, Uterus, Ovaries	Who:	Age:
Ulcerative Colitis	Who:	Age:
Crohn's Disease	Who:	Age:
Liver Disease	Who:	Age:
<b>Alcohol related? Yes or No</b>		
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 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** 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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**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

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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Jawahar L. Taunk, MD  
Mirela Onea, MD  
Corporate Office  
34041 US Hwy 19N  
Suite A  
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