# Advanced Gastroenterology Associates, LLC

*Providing leading-edge care with compassion*

***BOARD CERTIFIED IN GASTROENTEROLOGY***

*Sanjiv P. Amin, DO*
*Kevin Humphreys, MD*
*Mirela Onea, MD*
*Jawahar L. Taunk, MD*

*Corporate Office*
*34041 US Hwy 19N*
*Suite A*
*Palm Harbor, FL 34684*

*advancedgastro.com*

**DATE:** _______________

***Name**: ____________________________________________________________
Last First Middle-Initial

***Social Security # (last 4 digits required)**: _______________________ **SEX**: M F

***Date of Birth**: ________/__________/__________ **Age:** _____

***Local Address:** ____________________________________________________________

***City, State, Zip Code:** __________________________ _________ ____________

***Primary Language:** ____________________________________________________________

***Ethnicity:** **Hispanic/Latin** **Non-Hispanic/Latin** **Prefer not to answer**

***Race:** **American Indian / Alaska Native** **Native Hawaiian or another Pacific**
**Asian** **Black or African American** **White** **Hispanic** **Other**

***Home Phone #**: ______________________ **Cell Phone #:** _____________________

***E-mail address**: ____________________________________________________________

What is your out of state address & phone # if you have one?
_______________________________________________________________________

***Pharmacy Name:** ______________________________________________________

Address: ____________________________________________________________

Phone: ____________________________ Fax: ______________________________

***Emergency Contact Information:** Name: ____________________________________

Relationship: _________________________ Phone #: ___________________________

***Primary Care Physician:** _____________________________________________

Phone #: ____________________________________________________________

Do you have an Advanced Directive? Yes No
If yes, who is it?

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**Name:** ________________________________ **DOB**: ____________

How did you hear about us? __________________________________

Do you have a primary care physician: No Yes

Dr. ______________________ Phone Number: _________________

Reason for today's visit: ____________________________________

**Allergies:** *check all that apply* Penicillin Sulfa Codeine

Latex Adhesive Tape Other: _________________

When did you receive your last Flu Vaccine? _____________________

**List all medications/supplements you are currently taking:**

| Medication/Supplements | Dosage | Frequency | Reason for taking |
|---|---|---|---|
| EXAMPLE: Aspirin | 81 mg | Once a day | Prevention |
| | | | |
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# Advanced Gastroenterology Associates, LLC

**Name**: ________________________________ **DOB**: ___________

**Medical History:**

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

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

**Other Cancers:**

Skin Breast Uterine Ovarian Prostate Year Diagnosed: __________

**Other medical conditions not listed:**

# Advanced Gastroenterology Associates, LLC

**Name**: ___________________________________ **DOB**: ____________

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

| Surgery | | Surgery | | Surgery | |
|---|---|---|---|---|---|
| Oral surgery | | Eye surgery | | Carpal Tunnel Release | |
| Appendectomy | | Umbilical Hernia Repair | | Shoulder Surgery | |
| Colon/Small Bowel Resection | | Ulcer Surgery | | Back/Disc Surgery | |
| Hemorrhoidectomy | | Tonsillectomy | | Joint Replacement<br>Type: | |
| Colostomy (not colonoscopy) | | Coronary Artery Bypass | | Prostate Surgery | |
| Ileostomy | | Pacemaker | | Tubal Ligation | |
| Hiatal Hernia Surgery | | Coronary Stent Placement | | Prostate Surgery | |
| Gallbladder | | Arterial Stents | | Hysterectomy | |
| Weight Loss Surgery<br>Type: | | Heart Valve Replacement<br>Select: | | Cesarean Section(s)<br>Number: | |
| Inguinal Hernia<br>Repair Type: | | Implanted Defibrillator<br>Select: | | Mastectomy<br>Select: | |

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:

**Family History: blood relative** (not yourself or spouse) had the following?

| Condition | Who | Age |
|---|---|---|
| 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:**<br>Breast Uterus Ovaries | Who: | Age: |
| Ulcerative Colitis | Who: | Age: |
| Crohn's Disease | Who: | Age: |
| Celiac Desease | Who: | Age: |
| Liver Disease: **Alcohol related?**<br>**Yes** **No** | Who: | Age: |
| Diabetes | Who: | Age: |
| Hypertension | Who: | Age: |

**Name**: ________________________________ **DOB**: ___________

**Personal History:** **Please answer ALL questions.**

**Do you smoke? Yes No**

If yes, what year did you start smoking? ____________________________________

How much per day do you smoke? _________________________

Do you smoke: cigarettes pipe cigars chew tobacco

If no, have you ever smoked? Yes No

If no and you are an EX-SMOKER what year did you stop smoking? ______________

How much per day did you smoke? ________________________

Did you smoke: cigarettes pipe cigars chew tobacco?

Have you ever used: heroin cocaine marijuana methamphetamine

Intravenously? Yes No If yes, how long ago? _____________

Have you had a blood transfusion? Yes No What year? _______________

Do you have tattoos? Yes No

Do you have body piercings (including ears)? Yes No

**Alcohol use**: Yes No

What do you drink? Beer Liquor Wine

I have ____________ drinks per week day month year

Married Single Divorced Separated Widowed Significant Other

How many children do you have? ___________________________

Occupation: _________________________________________ Retired: Yes No

**Name**: ________________________________ **DOB**: ___________

## REVIEW OF SYSTEMS

Do you **currently** have any of the following? (Please check 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/did you have excessive bleeding with your period? Yes No

Number of pregnancies: ____________

Number of children: _________________

Breast lumps? Yes No

Menopause (period stopped) occurred at age: ____________

*Advanced Gastroenterology Associates, LLC*

**Name**: ________________________________ **DOB**: ___________

**Current Gastrointestinal/Liver Problems:**

(Please check 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

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:**

# 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 its 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. If in the event 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 DOB

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## Notice of Privacy Practices (HIPAA)

**Acknowledgement:**

I have read the copy of the Advanced Gastroenterology Associates, LLC Notice of Privacy Practices. (*You will have the opportunity to read when you arrive at the office*)

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 the above, I hereby provide informed consent to Advanced Gastroenterology Associates, LLC.**

**Patient's Signature:** __________________________________ **Date:** ___________________

**Print Name:** ___________________________________________

**Guardian's Signature**: __________________________________

Save this form, then attach to an email and send to: am@advancedgastro.com