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Thank you for choosing the office of **DRS. PALTROWITZ, SCHMIDT, MICALÉ, PALANCE, RIGOGLIOSO and LIN**. You will receive an automated phone call to confirm your appointment 3 days in advance of your appointment date. Please make every effort to **Confirm and keep your scheduled appointment**.

Attached to this e-mail you will find important information about parking, directions to our office, a patient information sheet, our **HIPAA** notice of privacy practices and acknowledgement form, and a health history questionnaire.

In order to help us get acquainted with your Medical History, and to expedite the paperwork associated with your visit, please:

- **Complete the enclosed forms and BRING THEM on the day of your visit. If you are unable to complete them on your own, please have a family member assist you or come to your appointment 30 minutes early so we can assist you.**
- **Bring a complete list of your CURRENT MEDICATIONS.**
- **Bring any RECENT LAB RESULTS, CT SCANS, MRIs or ULTRASOUNDS of the Abdomen, or any testing that is related to the reason why you are seeing the doctor.**
- **Bring your INSURANCE CARDS, PHOTO IDENTIFICATION and ANY NECESSARY REFERRAL from your primary care physician.**

To avoid any inconvenience, please check with your insurance company to see if a REFERRAL is required BEFORE your visit. If one is required, IT IS YOUR RESPONSIBILITY to obtain one and bring it to your appointment. **WITHOUT A VALID REFERRAL, YOU WILL BE RESPONSIBLE FOR THE BILL.**

If you have not provided your insurance information at the time you scheduled your appointment, please call the office prior to your visit with your INSURANCE INFORMATION so we may verify your benefits prior to your appointment.

PAYMENT is expected as services are rendered. Please be prepared to pay your copay at the time of your visit. We gladly accept cash, checks, American Express, Discover, Visa and MasterCard.

We look forward to meeting you and helping you with your medical needs. If you have any further questions, please don't hesitate to contact the office.

FASTING IS NOT REQUIRED ON THE DAY OF YOUR CONSULTATION VISIT.

IF YOU ARE GOING TO BE LATE FOR YOUR APPOINTMENT, PLEASE CALL THE OFFICE TO SEE IF WE CAN STILL ACCOMMODATE YOU.

THESE FORMS CAN ALSO BE ACCESSED ON OUR WEBSITE. PLEASE VISIT WWW.PGSMP.COM, CLICK ON THE FORMS TAB AND DOWNLOAD THE NECESSARY PAPERWORK HIGHLIGHTED IN RED

DIPLOMATES OF THE AMERICAN BOARDS OF GASTROENTEROLOGY

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____

Address: _____
STREET CITY STATE ZIP

Date of Birth : ____/____/____ SS #: _____ HAVE YOU BEEN A PATIENT OF OURS IN THE PAST? Y / N

HAVE YOU EVER USED ANOTHER NAME: Y / N If so, Please provide: _____

GENDER AT BIRTH: M / F GENDER IDENTITY: M / F MARITAL STATUS: Single / Married / Separated / Divorced / Widowed

ETHNICITY: Hispanic / Not Hispanic RACE: American Indian / Alaskan / Asian / Black / Mixed Race / Pacific Islander / White

PRIMARY LANGUAGE: _____

NOTIFY IN CASE OF EMERGENCY: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

EMPLOYER: _____ Occupation: _____

Employer Address: _____ Phone: _____

Please provide your phone numbers in the order you wish to be contacted:

Phone 1: _____ cell home work / Phone 2: _____ cell home work

The PATIENT PORTAL gives our patients secure, up to the minute access to their medical records, diet and educational forms, appointment, refill, billing history and statements. PLEASE NOTE: PATIENT PORTAL ACCESS REQUIRES AN E-MAIL ADDRESS.

Would you like to receive Paperless Billing Statements through the Patient Portal? ____ yes ____ no

E-MAIL Address: _____ Each patient must have their own unique email address.

Primary Care Physician: _____ Referring Physician: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

OUR PRACTICE SENDS PRESCRIPTIONS ELECTRONICALLY. THIS REQUIRES YOUR PHARMACY INFORMATION.

Local Pharmacy Name: _____ City: _____ Phone: _____

Mail Order Pharmacy: _____

PLEASE PROVIDE YOUR INSURANCE CARDS FOR SCANNING AT EACH VISIT.

INSURANCE: _____ ID: _____

SUBSCRIBER: _____ DOB: _____

INSURANCE: _____ ID: _____

SUBSCRIBER: _____ DOB: _____

I understand that I am responsible for my bill. I understand that if my insurance requires a referral, I will provide it at the time of my visit or reschedule until such time as I can provide the necessary referral. I authorize Drs. Paltrowitz, Schmidt, Micale, Palance, Rigoglioso, Lin and/or their employees to:

- Release any information to my insurance companies necessary for processing my insurance claim. A copy of this authorization can be used in place of the original.
- Receive direct payment from my insurance companies
- Release to and receive from any laboratories, hospitals, doctors or other healthcare providers, any information regarding my medical condition(s) and medical history necessary to treat me and coordinate my healthcare.
- Leave results of the tests performed on me, which are considered within normal limits for my health status, on my home telephone recording device, cell phone, e-mail or given to a spouse or family member.
- Call me at work to remind me of my appointment or to request a return call. This request can also be left with a spouse, family member or on a home telephone recording device, cell phone or e-mail.
- Download my pharmacy benefits and my e-prescribe history
- Communicate with me through the Patient Portal
- Send my statement via the Patient Portal (only when providing an e-mail address)

Patient Signature: _____ Date: _____

Drs. Paltrowitz, Schmidt, Micale, Palance, Rigoglioso & Lin

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA) , I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Notification of any breaches in unsecured Protected Health Information

I have received and read and understand your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact his organization to obtain a copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, they you are bound to abide by such restrictions.

PRINT Patient Name: _____ **Date of Birth:** _____

Signature: X _____ **Date:** _____

I will allow Drs. Paltrowitz, Schmidt, Micale, Palance, Rigoglioso & Lin or their designees to discuss my protected health information with the following person(s) listed below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

HEALTH HISTORY

NAME: _____ DOB: _____ Today's Date: _____

CHIEF COMPLAINT: (What brings you here today?): _____

PAST MEDICAL HISTORY: Please indicate any significant medical conditions: No Significant Past History

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke	<input type="checkbox"/> Colon Polyps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Kidney Disease	Other: _____	
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	_____	

FEMALES: DATE OF LAST MENSTRUAL PERIOD _____

PAST SURGICAL HISTORY: List any surgeries you have had, where they were performed and the approximate year. Please be sure to specifically include any surgeries of the abdomen, chest, head and neck. If none, please indicate **NONE**.

Surgery: _____ Doctor/Facility: _____ When: _____

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Surgery: _____ Doctor/Facility: _____ When: _____

Surgery: _____ Doctor/Facility: _____ When: _____

HAVE YOU EVER HAD A COLONOSCOPY BEFORE? YES NO Where _____ When _____

HAVE YOU EVER HAD AN UPPER ENDOSCOPY BEFORE? YES NO Where _____ When _____

MEDICATIONS: Please List ALL Medications you take, both Prescription and Over the Counter. If you take NO MEDICATIONS, please indicate NONE.

ALLERGIES – Please list any and all allergies in the appropriate category, or indicate NONE

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____ **ENVIRONMENTAL ALLERGIES:** _____

HAVE AN ALLERGY TO: IV CONTRAST? Y N IODINE? Y N PROBLEMS WITH ANESTHESIA IN THE PAST? Y N

SOCIAL HISTORY: Please indicate which of the following substances you use and the frequency of use:

Tobacco? Never Previously but quit YES _____ # Packs per day _____ # of years smoking

Alcohol? Never Rarely Socially Moderately Daily _____ # of drinks per day

Drugs? Never Previously but quit **IV Drugs? Yes or No**

Caffeine? Never Rarely Socially Moderately Daily _____ # of drinks per day

MARITAL STATUS: Single Married Partnered Separated Divorced Widowed

Name: _____ DOB: _____

FAMILY HISTORY: Please tell us about your family history. Be sure to include cancers of all kinds as well as those of the GI tract and liver.
(circle living or deceased)

Mother: _____ Living / Deceased at age _____

Father: _____ Living / Deceased at age _____

Sister: _____ Living / Deceased at age _____

Brother: _____ Living / Deceased at age _____

Children: _____ Living / Deceased at age _____

Grandparents: _____ Living / Deceased at age _____

REVIEW OF SYSTEMS – Please indicate any personal history below by circling the appropriate response.

CONSTITUTIONAL			Chronic cough	no	yes	Rash or itching	no	yes
Weight Gain	no	yes				Sores	no	yes
Weight Loss	no	yes	GASTROINTESTINAL					
Fever	no	yes	Rectal bleed/ blood in stool	no	yes	NEUROLOGIC		
Fatigue	no	yes	Painful bowel movements	no	yes	Dizziness	no	yes
Headaches	no	yes	Nausea or vomiting	no	yes	Headaches	no	yes
			Change in Bowel mvmts	no	yes	Mental Status Change	no	yes
			Abdominal pain	no	yes			
EYES			Constipation	no	yes	PSYCHIATRIC		
Blurred or double vision	no	yes	Loss of appetite	no	yes	Insomnia	no	yes
Wear glasses/contact	no	yes	Diarrhea	no	yes	Depression	no	yes
			Hemorrhoids	no	yes	Anxiety	no	yes
			Hepatitis	no	yes			
			Anorexia	no	yes	ENDOCRINE		
			Gas and Bloating	no	yes	Diabetes	no	yes
			Reflux/Heartburn	no	yes	Hormone/glandular		
EARS/NOSE/MOUTH/THROAT			Increased abdominal girth	no	yes	Problems	no	yes
Bad breath or bad taste	no	yes	Jaundice	no	yes			
Mouth Sores	no	yes	Difficulty Swallowing	no	yes	HEME/LYMPH		
Sore throat	no	yes				Blood Clots	no	yes
Swollen glands in neck	no	yes	GENITOURINARY			Bruising	no	yes
Wear Dentures	no	yes	Kidney Stones	no	yes	Transfusions	no	yes
			Urinary Incontinence	no	yes	Enlarged Glands	no	yes
			Burning or painful urination	no	yes	Taking Blood Thinners?	no	yes
CARDIOVASCULAR			Blood in urine	no	yes			
Swelling of extremities	no	yes	Urinary frequency	no	yes			
Arrhythmia	no	yes						
Shortness of Breath	no	yes	MUSCULOSKELETAL					
Chest pain/pressure	no	yes	Neck Pain	no	yes			
			Back Pain	no	yes			
			Joint Replacement	no	yes			
RESPIRATORY								
Sleep Apnea	no	yes	DERMATOLOGIC					
COPD/Emphysema	no	yes	Change in hair or nails	no	yes			
Wheezing	no	yes	Change in skin color	no	yes			

Name of Blood Thinner (if any)

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian: X _____ Date: _____

Signature of Physician _____ Date: _____

DIRECTION TO 1086 TEANECK ROAD, TEANECK, N.J. 07666

Located Just North of Route 4

FOR GPS: PLEASE USE 1090 KATHERINE STREET, TEANECK, NJ

FROM ROUTE 4 EAST OR WEST - Exit Route 4 at **Teaneck Road, Bergenfield Exit (this is important since the Bergenfield Exit puts you north on Teaneck Road)**. At the end of the ramp go straight onto Teaneck Road (from the East, make a right onto Teaneck Road). At the first traffic light, make a left onto Selvage Avenue. Make the first left onto Katherine Street and proceed into the parking area.

FROM ROUTE 80 EAST - Take Route 80 to Exit 70 marked Teaneck/Leonia. This is just past the NJ Turnpike South Exit. Stay in the right lane. Go to the second turnoff marked 70B TEANECK. Follow the road to the second traffic light (make sure you stay to the right) and make a right onto Teaneck Road. Continue North on Teaneck Road to the 5th traffic light. (as soon as you go under the Route 4 overpass, you will approach this traffic light). Make a left onto Selvage Avenue and the first left onto Katherine Street. Proceed into the parking area.

FROM ROUTE 17 NORTH AND SOUTH - Take Route 17 to Route 4 East and follow the Route 4 directions above.

FROM THE GARDEN STATE PARKWAY – NORTHBOUND - Travel the Garden State Parkway to Exit 161 which puts you on Route 4 East. Please follow the Route 4 directions listed above.

FROM THE GARDEN STATE PARKWAY – SOUTHBOUND - Travel the Garden State Parkway to Exit 163 which puts you on Route 17 South. Proceed 1.5 miles to Route 4 East. Follow the directions for Route 4 listed above.

FROM THE GEORGE WASHINGTON BRIDGE - Take the George Washington Bridge to Route 4 West and follow the directions for Route 4 listed above.

**** IMPORTANT INFORMATION ABOUT PARKING ****

DESIGNATED PARKING SPACES FOR DR. PALTROWITZ, SCHMIDT, MICALE, PALANCE, RIGOGLIOSO & LIN AS WELL AS TEANECK GASTROENTEROLOGY AND ENDOSCOPY CENTER ARE AS FOLLOWS:

FIRST LEVEL (STREET LEVEL) - SPACES ARE LOCATED IMMEDIATELY TO YOUR RIGHT AS YOU ENTER THE PARKING LOT OFF OF KATHERINE STREET. THESE SPACES ARE MARKED WITH A YELLOW STRIPE AND LABELED GI. IF THESE SPACES ARE OCCUPIED, YOU MAY PARK IN ANY SPACE LABELED VISITOR.

LOWER LEVEL (UNDER THE BUILDING) - SPACES ARE LOCATED IN THE SECOND ROW ON THE LEFT SIDE OF THE LOT. THEY ARE #35, #36, #37, #38, #39 AND ARE ALL LABELED GI. IF THESE SPACES ARE OCCUPIED, YOU MAY PARK IN ANY SPACE THAT DOES NOT HAVE A NAME. ALL PERIMETER PARKING IN THE LOWER LEVEL IS FOR VISITORS.

IF YOU PARK IN A SPACE BELONGING TO ANOTHER OFFICE...YOU WILL BE TOWED AT YOUR EXPENSE!