MICHAEL SCHMIDT, M.D.
PHILIP MICALE, M.D.
ADAM PALANCE, M.D.
VINCENT RIGOGLIOSO, M.D.
JUDY LIN, M.D.

1086 Teaneck Road * Suite 4C * Teaneck, New Jersey * 07666
Phone: 201-837-9449 Fax: 201-578-1699

Thank you for choosing the office of **DRS. SCHMIDT, MICALE, 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.**

APPOINTMENT DATE: ______________________________ TIME:_________________________________

Attached 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 BOARD OF GASTROENTEROLOGY

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 DRS. 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!

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:____

YOUR EMPLOYER:____**Occupation:**__________________________________

Your Employer Address:____**Phone:** _________________________

NOTIFY IN CASE OF EMERGENCY: ________________________ **PHONE NUMBER**:_________________**RELATIONSHIP:**______________

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. 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. 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 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:____

____

____

1086 Teaneck Road * Suite 4C * Teaneck, New Jersey * 07666

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

___ Anemia
___ Asthma
___ Cancer
___ Cirrhosis
___ Diabetes
___ Heart Disease
___ Hernia
___ High Blood Pressure
___ HIV/AIDS
___ Joint Replacement
___ Kidney Disease
___ Pneumonia
___ Stroke
___ Ulcers
Other:________________________________
____
___ Colon Polyps

FEMALES: DATE OF LAST MENSTRUAL PERIOD _______________________

RECENT TRAVEL OUTSIDE THE COUNTRY ? ______YES _____NO Where?___________________________

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:___________

Surgery:__________________________________ Doctor/Facility:_____________________________ When:___________

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 CONTAST? 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

Weight Gain	no	yes
Weight Loss	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

EYES

Blurred or double vision	no	yes
Wear glasses/contact	no	yes

EARS/NOSE/MOUTH/THROAT

Bad breath or bad taste	no	yes
Mouth Sores	no	yes
Sore throat	no	yes
Swollen glands in neck	no	yes
Wear Dentures	no	yes

CARDIOVASCULAR

Swelling of extremities	no	yes
Arrhythmia	no	yes
Shortness of Breath	no	yes
Chest pain/pressure	no	yes

RESPIRATORY

Sleep Apnea	no	yes
COPD/Emphysema	no	yes
Wheezing	no	yes
Chronic cough	no	yes

GASTROINTESTINAL

Rectal bleed/ blood in stool	no	yes
Painful bowel movements	no	yes
Nausea or vomiting	no	yes
Change in Bowel mvmts	no	yes
Abdominal pain	no	yes
Constipation	no	yes
Loss of appetite	no	yes
Diarrhea	no	yes
Hemorrhoids	no	yes
Hepatitis	no	yes
Anorexia	no	yes
Gas and Bloating	no	yes
Reflux/Heartburn	no	yes
Increased abdominal girth	no	yes
Jaundice	no	yes
Difficulty Swallowing	no	yes

GENITOURINARY

Kidney Stones	no	yes
Urinary Incontinence	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Urinary frequency	no	yes

MUSCULOSKELETAL

Neck Pain	no	yes
Back Pain	no	yes
Joint Replacement	no	yes

DERMATOLOGIC

Change in hair or nails	no	yes
Change in skin color	no	yes
Rash or itching	no	yes
Sores	no	yes

NEUROLOGIC

Dizziness	no	yes
Headaches	no	yes
Mental Status Change	no	yes

PSYCHIATRIC

Insomnia	no	yes
Depression	no	yes
Anxiety	no	yes

ENDOCRINE

Diabetes	no	yes
Hormone/glandular Problems	no	yes

HEME/LYMPH

Blood Clots	no	yes
Bruising	no	yes
Transfusions	no	yes
Enlarged Glands	no	yes
Taking Blood Thinners?	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:**_____________________