Office Use Only:
Account #: _____ Insurance Co.: _____ Referring Dr.: _____

PATIENT HISTORY - REVIEW OF SYSTEMS SS#

Date: _____ Patient Name: _____ Date of Birth _____

Occupation: _____ ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Reason for Visit: _____ Pharmacy: town

Do you have any allergies? If yes, please list: _____

Medicines:

List all prescriptions, over-the-counter drugs and vitamins you are currently taking

Taking Aspirin? ☐ No ☐ Yes

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any of the following?

☐ Mitral Valve Prolapse
☐ Artificial Heart Valves
☐ History of Heart Valve Infections
☐ Valvular Heart Disease
☐ Aneurysm
☐ Heart Murmur
☐ Colon Cancer
☐ Inflammatory Bowel Disease
☐ Colitis
☐ Artificial Joints

Do you have a Family History of:

☐ Colon Cancer ☐ Heart Disease
☐ Diabetes ☐ Liver Disease
☐ Inflammatory Bowel Disease

Do you Smoke now or have you in the past? ☐ **Yes** ☐ **No**

Do you Drink now or have in the past? ☐ **Yes** ☐ **No**

Surgeries (check all that apply):

Cardiac	☐ No	☐ Yes	Year _____
Appendix	☐ No	☐ Yes	Year _____
Gallbladder	☐ No	☐ Yes	Year _____
Stomach	☐ No	☐ Yes	Year _____
Small Intestine	☐ No	☐ Yes	Year _____
Kidney	☐ No	☐ Yes	Year _____
Colon	☐ No	☐ Yes	Year _____
Lung	☐ No	☐ Yes	Year _____
Hernia	☐ No	☐ Yes	Year _____

Other _____

Other _____

Men:

Prostate ☐ No ☐ Yes Year _____

Women:

Breast ☐ No ☐ Yes Year _____
Uterus ☐ No ☐ Yes Year _____
Ovaries ☐ No ☐ Yes Year _____

Date of Last Menstrual Period _____

Do you think you might be pregnant: ☐ Yes ☐ No

Constitutional

Recent weight change ___ No ___ Yes
Fever ___ No ___ Yes
Fatigue ___ No ___ Yes

Eyes

Blurred Vision ___ No ___ Yes
Glaucoma ___ No ___ Yes

Ears/Nose/Mouth/Throat

Hearing Loss ___ No ___ Yes
Ringing in ears ___ No ___ Yes
Mouth sores ___ No ___ Yes

Cardiovascular

Chest pain ___ No ___ Yes
Hypertension ___ No ___ Yes
H/O Heart attacks ___ No ___ Yes
Shortness of breath ___ No ___ Yes
Swelling of ankles ___ No ___ Yes

Respiratory

Emphysema ___ No ___ Yes
Asthma ___ No ___ Yes
Chronic cough ___ No ___ Yes
Spitting up blood ___ No ___ Yes
Wheezing ___ No ___ Yes

Genitourinary

Burning with urination ___ No ___ Yes
Blood in urine ___ No ___ Yes

Gastrointestinal

Poor appetite ___ No ___ Yes
Difficulty in swallowing ___ No ___ Yes
Heartburn ___ No ___ Yes
Nausea or Vomiting ___ No ___ Yes
Bloating ___ No ___ Yes
Belching ___ No ___ Yes
Regurgitation ___ No ___ Yes
Constipation ___ No ___ Yes
Diarrhea ___ No ___ Yes
Abdominal pain ___ No ___ Yes
Change in bowel habits ___ No ___ Yes
Rectal Bleeding ___ No ___ Yes
Black, tarry stools ___ No ___ Yes
H/O Ulcer ___ No ___ Yes
H/O Gallbladder disease ___ No ___ Yes
H/O Colon Cancer ___ No ___ Yes
Pancreas ___ No ___ Yes

Neurological

Headaches ___ No ___ Yes
Seizures ___ No ___ Yes
Strokes ___ No ___ Yes
Numbness ___ No ___ Yes

Psychiatric

Memory loss/confusion ___ No ___ Yes
Depression ___ No ___ Yes

Musculoskeletal

Joint pain and/or swelling ___ No ___ Yes
Back pain ___ No ___ Yes
Muscle pain ___ No ___ Yes

Endocrine

Diabetes ___ No ___ Yes
Heat or cold intolerance ___ No ___ Yes
Excessive thirst or urination ___ No ___ Yes
Thyroid disease ___ No ___ Yes

Hematological

Bleeding/bruising tendency ___ No ___ Yes
Anemia ___ No ___ Yes
Past Transfusion ___ No ___ Yes

Skin

Rash ___ No ___ Yes
Itching ___ No ___ Yes

Liver Disease

Hepatitis ___ No ___ Yes
Jaundice ___ No ___ Yes

For Office Use Only

Reviewed:

Date: _____ By: _____ Date: _____ By: _____
Date: _____ By: _____ Date: _____ By: _____

DIGESTIVE HEALTH AND NUTRITION CENTER, LLC

465 Cranbury Road, Suite 102
East Brunswick, New Jersey 08816
Telephone: (732)390-1995
Fax: (732)254-4610

Allan Plumser, M.D. **Jose Costa, M.D.**

OFFICE POLICIES – *initial on every line*

_____I understand if I miss a scheduled appointment without canceling 24 hours in advance, there will be a $50.00 fee charged directly to me.

_____ I understand if I have a scheduled procedure and do not appear or without canceling 24 hours in advance, there will be a $100.00 fee charged directly to me.

_____Co-pays are due BEFORE service is rendered. There will be a $25.00 charge if our office needs to bill me for my co-pay.

_____There will be a $25.00 charge for all return checks.

_____If a referral is required and is not presented at the time of your visit, you will be responsible for the charge for services rendered.

_____If your insurance has changed, you are responsible for notifying the office as soon as possible. Failure to do so, can result in having your office visit and/or procedure denied because the pre-certification or authorization was done for the wrong insurance information was given. If this occurs you will be responsible to remit payment in full for serviced rendered.

_____You agree, in order for us to service your account or to collect any monies you may owe, we may contact you by telephone. We will contact you on any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

FINANCIAL AGREEMENT – *print, sign and date on the line below*

I acknowledge that payment is due for the medical services I receive. As a courtesy, the billing staff will submit a claim to my insurance company. I accept full financial responsibility for all charges for services that are rendered to me. I understand that filing a claim with my insurance company does not relieve me of my responsibility for the payment for the balance of these charges.

******It is quite likely that your insurance company will pay for all or most of your bill. Deductible, co-insurance and co-pay can not be waived for Medicare and managed care insurances, except under special circumstances******

I acknowledge that a charge of 1.5% will be added monthly onto my balance that is more than 30 days past due. Please note, if a delinquent account is sent to SAVIT Collection Agency, there will be an additional collection fee of $50.00 or 20% of the balance owed, whichever is greater.

You agree, in order for us to service your account or to collect any monies you may owe, we may contact you by telephone. We will contact you on any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

Print Name: _____

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the *Notice of Privacy Practices*

Print Patient Name: _____

Signature of Patient: _____

Date: _____

I authorize Digestive Health and Nutrition Center, LLC to discuss/release my medical and/or financial information to those listed below.

NAME	RELATIONSHIP	TELEPHONE NUMBER

For Office Use:

If patient/representative requested a copy of Notice, Date copy was provided: _____

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement:

_____

_____

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NOTICE OF PRIVACY PRACTICES SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THS INFORMATION.
PLEASE REVIEW IT CAREFULLY

OUR PRIVACY OBLIGATIONS

We are required by law to maintain the privacy of your health information ("Protected Health Information" or 'PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice which may be amended from time to time. In all cases where we may share your medical information with others, we share on the **minimum necessary** amount of information required to satisfy the need or request.

PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR WRITTEN AUTHORIZATION

Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our "health care operations."

- **Treatment** – We use and disclose your PHI to provide treatment and other services to you—for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Payment** – We may use and disclose your PHI to obtain payment for services that we provide to you—for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care to verify that your health plan will pay for the health care.
- **Health Care Operations** – We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you.
- **Disclosure to Relatives, Close Friends and Other Caregivers** – We may disclose your PHI to those people who are involved in your care or designated to you.
- **Public Health Activities** – We may use and disclose your PHI when reporting communicable diseases or when complying with the Food and Drug Administration requirement for reporting adverse reactions and for health oversight by the government.
- **Judicial and Administrative Proceedings –** We may use and disclose your PHI in response to legal orders, subpoenas and court proceedings.
- **Law Enforcement and Government Functions –** We may use and disclose your PHI when faced with issues related to threats against you or against the public. Also, we may use and disclose your PHI in response to police, military, and national security requirements and orders. We may use or disclose your PHI if law or regulations required the use of disclosure.
- **Workers Compensation/Social Security Disability**
- **Organ and Tissue Procurement for Organ Donors/Decedents to Medical Examiners**
- **Victims of Abuse or Violence**

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YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- Right to inspect and copy your health information
- Right to request additional restrictions
- Right to receive confidential communication
- Right to revoke your authorization
- Right to amend your records
- Right to receive an accounting of disclosures
- Right to receive a copy of this notice