

Gregg Polidori, MD, FACP, FACG Robert H. Goo, MD, FACP, FACG Sung K. Yang, MD Sami Akkary, MD, FACG Alexander Stojanovic, MD Dorene Hardie, RN, MSN, NP

Diplomates American Board of Internal Medicine & Gastroenterology

Appointment da	ate:	
With:		
Day:	Time:	
Location:		

Dear Patient:

Welcome to our practice. Enclosed you will find our new patient registration forms. Please be sure to complete these forms *prior to your appointment*. You may email or mail the forms, including a copy of your insurance cards (s), front and back, along with your drivers license and any medical records of prior testing or procedures. You may also bring them to your appointment, along with the insurance and identification. Please include a list of your medications.

Keep in mind, if your insurance requires a referral, please make sure to contact the primary physician and bring the referral with you to your appointment. Without the referral, you will be responsible for the office visit charge, due at the time of service. *Keep in mind, all copays and balances are due prior to seeing your doctor..*

Please arrive 15 minutes prior to your appointment time. If you are 15 minutes late to your scheduled appointment time, you will need to reschedule the appointment.

In the event you cancel your appointment, less than 24 hours of your appointment time, or fail to show, you will be assessed a \$25 fee. Please call the appropriate office to reschedule:

Royal Oak:248/551-0900 Southfield:248/353-3026 West Bloomfield 248/926-9660

Thank you for your time and we look forward to seeing you.

Sincerely,

The Staff of Oakland Gastroenterology Associates, P.C.



Oakland Gastroenterology Associates, PC

Gregg Polidori, MD, FACP, FACG Robert H. Goo, MD, FACP, FACG Sung K. Yang, MD Sami Akkary, MD, FACG Alexander Stojanovic, MD Dorene Hardie, RN, MSN, NP

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Last Name:	First Name:		MI:			
Address	City	State	_ Zip			
Home phone	Cell	Work				
Date of Birth	Social Sec#	Employer				
Male/Female Single/Married	RaceLa	nguage spoken_				
e-mail address:						
Referring Physician:	Pho:	ıe:				
Primary Physician:	Pho	ne:				
Spouse's Name:	Date o	f Birth:				
Emergency Contact:	Phone:		Relation:			
Are you: Employed Full Time/ Part Tin	ne/ Not Employed/ Self Employed	/ Retired/ Active Di	uty/ Student			
Is this a Workman's Comp or Auto Insuranc	e Claim? Yes/ No Date of Injury	Claim #:				
Workman's Comp or Auto Carrier	Address & Phone					
Assignment of Insurance I hereby authorize direct payment of surgical/medical benefits to Dr for services rendered by him or any person under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. Authorization to Release Information I hereby authorize Dr to release any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefit. Medicare/Medicaid I certify that the information given by applying for payment is correct. I authorize the release of all records upon request. I request payment of authorized benefits be made on my behalf. Co-pays/authorizations I understand that it is my responsibility as the patient to know my insurance. All co-pays and Master Medical payments are due at the time of service. If a referral is needed, it is also my responsibility to obtain and bring it at the time of service.						
Patient Name (PRINT)	Signa	ature				
Parent/Guardian (if under 18y/a)	www.oaklandgastroassoc.co					

Authorization for Release of Information to Family Member or Friend Without Power of Attorney

I,	(patient), hereby give the following				
person(s) authorization to obtain info	(patient), hereby give the following rmation regarding my:				
Confirm appointments and leave messages Lab Work/Test Results Medical Records Information Billing Information All of the Above					
Person 1:	Relationship:				
Person 2:	Relationship:				
Person 3:	Relationship:				
Person 4:	Relationship:				
Person 5:	Relationship:				
I have received a copy of the privacy	policy.				
Patient Signature	Date				

PATIENT INFORMATION SHEET

Name						DOB					ate
Marital status: Single_		Marı	-	Divorced		Widowed		mbe	er of C	Children	
Physician: (Please circle)		LIDC	RI	GOO	YAN		KARY				NOVIC
Primary Care Physician						EIGHT			VEIG		
It is important for our physician to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical record.											
PAST SURGICAL A											rformed.
MEDICAL HISTORY	The second secon	YES	NO	Onset, Comm		SURGICAL		ES	NO		e, Comments
			-			HISTORY					
Anorexia / Bulemia		Yes	No			Colon		l'es	No	WHEN?	WHERE?
Arthritis / Joint swelling		Yes	No			Stomach		l'es	No	WHEN?	WHERE?
Asthma		Yes	No			Heart:	_	l'es	No	WHEN?	WHERE?
Bleeding disorder		Yes	No			Stent / Bypa		es	No	WHEN?	WHERE?
Blood or infectious diseas		Yes	No			Valve		l'es	No	WHEN?	WHERE?
Cancer, Type:		Yes	No	WHEN? WHERE		Pacemaker	_	es	No	WHEN?	WHERE?
Colon polyps		Yes	No	WHEN? WHERE		Defibrillator		l'es	No	WHEN?	WHERE?
Crohn's disease		Yes	No	WHEN? WHERE	?	Joint replacen		/es	No	WHEN?	WHERE?
Diabetes		Yes	No			Gallbladder		/es	No		
Epilepsy / seizures		res	No			Hysterectom	7	es	No		
Gallstones		/es	No			Appendix		es	No		
Glaucoma	Y	l'es	No			Prostate	7	/es	No		
Headaches/ fainting/ dizzi	ness Y	Zes	No			Bladder	7	es	No		
Heart problems/ Chest pai	in Y	l'es	No	WHEN? WHERE	?	C-section	7	es	No		
Hepatitis / Liver problems	S Y	l'es	No			Breast	7	es	No		
Hiatal hernia / GERD	Y	Zes	No	WHEN? WHERE	?	Other surger	ies				
High / low Blood pressure	Y	/es	No			Other surger	ies				
Kidney disease	Y	res	No			Other surger	ies				
Lung Disease	Y	es	No			Other surger	ies				
Pacemaker / Internal defibri	llator Y	es	No			Anesthesia Probl	ems Y	'es	No		
Sleep Apnea	Y	/es	No			Previous EGD		res	No	WHEN?	WHERE?
Stomach problems / ulcers	S Y	Zes	No			Prev Colonosc	ору Ү	res	No	WHEN?	WHERE?
Stroke			No			Vaccination				nd date)
Thyroid problems	Y	'es	No			Hepatitis A	Y	res	No		
Tuberculosis	Y	res	No			Hepatitis B	Y	res	No		
Ulcerative Colitis	Y	'es	No								
Other											
Other											
** Preferred Pharmacy a	nd Phor	ne N	umbe	<u>er</u> :						30	
ALL CURRENT MEDICA Medication	TIONS: Dosage	*P		include all vitan s per day	Medic		elievers A		O RECI Dosage		es per day
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**ALLERGIES R	EACTIO	N		ALLERGIES		REACTION		ALI	ERGI	ES	REACTION
	2110110		-	·							

SOCIAL HISTORY: (Past or Current) Alcohol Yes No Quit Duration & Amount	Name			Sex: F	\mathbf{M}	DOB	A	ge	Date
Alcoholo Yes No Quit Duration & Amount Coffee / Caffeine Yes No Quit Duration & Amount Substance Abuse Yes No Quit Duration & Amount Tobacco Yes No Quit Duration & Amount Blood Transfusions Yes No When? Tattoos Yes No When? Tattoos Yes No How much? FAMILY HISTORY: Please indicate any RELATIVES with the following diseases. Who? Alcoholism Yes No Who? Alcoholism Yes No Cirrhosis / Jaundice Yes No Cirrhosis / Jaundice Yes No Colon Cancer Yes No Diabetes Yes No Diabetes Yes No Hemachromatosis Yes No									
Coffee / Caffeine		-			Dura	tion & Amount			
Substance Abuse		-			Dura	tion & Amount			
Tobacco					Dura	ation & Amount			
Blood Transfusions Yes No What time do you stop eating at night? What time do you go to bed?									
Tattoos		-	-						
Do you exercise?		Yes	No	What time do you	ı stop	eating at night?	W	hat time d	o you go to
Symptom Review Symptoms you have had in the past 3 months Symptoms so for breath Short mass all congestion Short mass all congestion Short mass all congestion Short mass all congestion Swallowing difficulties Short mass all congestion	Half Endered Half Winds			bed?	•				
Alcoholism	Do you exercise?	Yes	No	How much?					
Cirrhosis / Jaundice		RY: I	Please in	dicate any REI	LAT	IVES with the fo	ollowi	ng disea	ases.
Alcoholism Yes No Cirrhosis / Jaundice Yes No AT WHAT AGE DIAGNOSED? Colon Cancer Yes No AT WHAT AGE DIAGNOSED? Colon Cancer Yes No AT WHAT AGE DIAGNOSED? Colon or rectal polyps Yes No Corbin-3/Uccrative Colits Yes No Colon Cancer Yes No Cancer Ye								0	
Cirrhosis / Jaundice Yes No AT WHAT AGE DIAGNOSED? Colon Cancer Yes No AT WHAT AGE DIAGNOSED? Colon or rectal polyps Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes No Heart disease Yes No Heart disease Yes No Heart disease Yes No Diabetes Yes No Heart disease Yes No Heart disease Yes No Diabetes Yes No Diabetes Yes No Heart disease Yes No Diabetes Yes No Di	Alcoholism	Ves	No	,,,,,					
Colon Cancer									
Colon or rectal polyps							AT WH	AT AGE DIA	GNOSED?
Cronh's/Ulcerative Colitis Yes No Diabetes Yes No Gallstones Yes No Hemachromatosis Yes No Heard disease Yes No High Blood Pressure Yes No SYMPTOM REVIEW Check (\overline{\over									
Diabetes Yes No Gallstones Yes No Hemachromatosis Yes No Hemachromatosis Yes No High Blood Pressure Yes No Liver Disease Yes No Liver Disease Yes No SYMPTOM REVIEW Check ((E)) symptoms you have had in the past 3 months Weight Loss Condition: Fever/Chills Shortness of breath Difficulty urinating Dry mouth Nausea / vomiting Swallowing difficulties Parin with swallowing Arthritis/Joint pain Hair loss Nasal congestion Diarrhea Nave or chronic rash Swollen Imagelian Diarrhea Naviety Diarrhea Swallowing Swallowing Scizures Other: Other: Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: This form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician Symptoms you have had in the past 3 months Frequent urination Depression Depression Anxiety Hearing Image Depression Depre									
Gallstones Yes No Hemachromatosis Yes No Hemachromatosis Yes No Heart disease Yes No High Blood Pressure Yes No									
Hemachromatosis Yes No									
Heart disease		-							
Symptom Review Check (S) symptoms you have had in the past 3 months Symptom Sympto	Heart disease								20204
SYMPTOM REVIEW Check (S) symptoms you have had in the past 3 months SYMPTOM REVIEW Check (S) symptoms you have had in the past 3 months Symptoms you have your have you have your have your have your have your have your have your had not hear of units Symptoms your have your have your heart you have your had not	High Blood Pressure	Yes	No						
□ Weight Loss □ Fever/Chills □ Shortness of breath □ Poor vision/double vision □ Dry mouth □ Dry mouth □ Frequent nosebleeds □ Frequent nosebleeds □ Frequent nosebleeds □ Pain with swallowing □ Hearring loss □ Pain with swallowing □ Hoarseness □ Diarrhea □ Constipation □ Headaches □ Swelling of ankles/legs Other: Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: Putient Sorm was filled out more than 30 days ago patient and physician with signature: Physician □ Reviewed By: Patient Signature: Physician □ Reviewed By: □ Cough □ Frequent urination □ Depression □ Anxiety □ Anxiety □ Depression □ Anxiety □ Depression □ Anxiety □ Depressi		Yes	No						
□ Weight Loss □ Fever/Chills □ Poor vision/double vision □ Dry mouth □ Frequent nosebleeds □ Pain with swallowing □ Hearring loss □ Pain with swallowing □ Hoarseness □ Diarrhea □ Constipation □ Headaches □ Swallen lymph nodes □ Irregular heart beat □ Blood in stool □ Reviewer Other: Other: Other: Physician notes if needed: Condition: Condition: Condition: Condition: Condition: Condition: Condition: Condition: Physician Physician Physician Physician Physician Physician Physician Physician									
□ Fever/Chills □ Poor vision/double vision □ Dry mouth □ Dry mouth □ Nausea / vomiting □ Blood in urine □ Hair loss □ Frequent nosebleeds □ Pain with swallowing □ Hair loss □ Pain with swallowing □ Hoarseness □ Diarrhea □ Diarrhea □ Nail changes □ Recessive bleeding □ Chest pain □ Constipation □ Headaches □ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: PULMONOLOGIST: Tf this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: □ Incontinence of urine □ Difficulty urinating □ Difficulty urinating □ Anxiety □ Anxiety □ Anxiety □ Anxiety □ Anxiety □ Anxiety □ Hair loss □ Hot/Cold sensitivity □ Excessive thirst □ Easy bruising □ Excessive bleeding □ Swollen lymph nodes □ Swelling of ankles/legs □ Swelling of ankles/legs □ Condition: Condition: Condition: Physician Physician Physician Physician Physician Physician	SYMPTOM REVIE	W Che	ck (🗵) sy	mptoms you hav	e had	in the past 3 mont	hs		
□ Poor vision/double vision □ Dry mouth □ Dry mouth □ Nausea / vomiting □ Frequent nosebleeds □ Swallowing difficulties □ Hearing loss □ Pain with swallowing □ Hot/Cold sensitivity □ Hearing loss □ Pain with swallowing □ Nausele aches □ New or chronic rash □ Nail changes □ Excessive thirst □ Easy bruising □ Headaches □ Irregular heart beat □ Constipation □ Headaches □ Swelling of ankles/legs Other: Other Physician notes if needed: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: Tf this form was filled out more than 30 days ago patient and physician will review and update: Patient signature: Physician □ Pointing □ Anxiety □ Hair loss □ Heart bum □ Anxiety □ Hair loss □ Heat/Cold sensitivity □ Excessive thirst □ Reviews or chronic rash	☐ Weight Loss		☐ Cough			☐ Frequent urination	on	☐ Mem	ory loss
□ Dry mouth □ Nausea / vomiting □ Frequent nosebleeds □ Swallowing difficulties □ Hearing loss □ Pain with swallowing □ Hoarseness □ Diarrhea □ Nausel aches □ Excessive thirst □ Rain loss □ Hoarseness □ Diarrhea □ Nail changes □ Excessive bleeding □ Swallen lymph nodes □ Swelling of ankles/legs Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: Tf this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician □ Blood in urine □ Hair loss □ Hot/Cold sensitivity □ Muscle aches □ Excessive thirst □ Revieweiting Arthritis/Joint pain □ Muscle aches □ Excessive thirst □ Revieweiting Headaches □ Excessive bleeding □ Swollen lymph nodes □ Swelling of ankles/legs	☐ Fever/Chills		☐ Shortn	ess of breath	1	☐ Incontinence of u	ırine	□ Depre	ession
□ Frequent nosebleeds □ Swallowing difficulties □ Hot/Cold sensitivity □ Hearing loss □ Pain with swallowing □ Muscle aches □ Excessive thirst □ Easy bruising □ Hoarseness □ Diarrhea □ Nail changes □ Excessive bleeding □ Chest pain □ Constipation □ Headaches □ Swollen lymph nodes □ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: PULMONOLOGIST: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: □ Arthritis/Joint pain □ Hot/Cold sensitivity □ Excessive bleeding □ Excessive bleeding □ Swollen lymph nodes □ Seizures □ Swelling of ankles/legs □ Condition: □ Condition: □ Condition: □ Condition: □ Condition: □ DATE: □ Physician □ Arthritis/Joint pain □ Muscle aches □ Excessive thirst □ Easy bruising □ Excessive bleeding □ Swollen lymph nodes □ Swelling of ankles/legs □ Swelling of ankles/legs □ Swelling of ankles/legs	☐ Poor vision/double v	ision	☐ Heart 1	ourn	1	☐ Difficulty urinati	ng	☐ Anxi	ety
□ Frequent nosebleeds □ Swallowing difficulties □ Arthritis/Joint pain □ Hot/Cold sensitivity □ Hearing loss □ Pain with swallowing □ Muscle aches □ Excessive thirst □ Easy bruising □ Hoarseness □ Diarrhea □ Nail changes □ Excessive bleeding □ Chest pain □ Constipation □ Headaches □ Swollen lymph nodes □ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: PULMONOLOGIST: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician □ Arthritis/Joint pain □ Hot/Cold sensitivity □ Excessive bleeding □ Excessive bleeding □ Swollen lymph nodes □ Seizures □ Swelling of ankles/legs □ Condition: Condition: Condition: Physician Physician	☐ Dry mouth					☐ Blood in urine		☐ Hair	loss
□ Hearing loss □ Nasal congestion □ Abdominal pain □ Hoarseness □ Diarrhea □ Diarrhea □ Nail changes □ Swollen lymph nodes □ Swelling of ankles/legs Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: □ Muscle aches □ New or chronic rash □ Nail changes □ Headaches □ Swollen lymph nodes □ Swelling of ankles/legs □ Swelling of ankles/legs □ Condition: □ Condition: □ Condition: □ DATE: □ Physician □ Physician □ Nail changes □ Excessive thirst □ Easy bruising □ Excessive bleeding □ Swollen lymph nodes □ Swelling of ankles/legs		s	☐ Swalle	wing difficulties		☐ Arthritis/Joint pa	in	☐ Hot/C	Cold sensitivity
□ Nasal congestion □ Abdominal pain □ New or chronic rash □ Easy bruising □ Hoarseness □ Diarrhea □ Nail changes □ Swollen lymph nodes □ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Other: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: PULMONOLOGIST: Tf this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician DATE: Physician						☐ Muscle aches		☐ Exces	ssive thirst
□ Chest pain □ Constipation □ Headaches □ Swollen lymph nodes □ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Other: Physician notes if needed: CARDIOLOGIST: PULMONOLOGIST: PULMONOLOGIST: Tf this form was filled out more than 30 days ago patient and physician will review and update: Patient signature: Physician Physician Physician						☐ New or chronic r	ash	☐ Easy	bruising
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□ Irregular heart beat □ Blood in stool □ Seizures □ Swelling of ankles/legs Other: Physician notes if needed: □ Cardition: □ Condition: □ Condi		1			- 1	_			_
Other: Physician notes if needed: Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: Condition: Condition: Condition: Condition: Condition: Patient Signature: Physician Physician	1				- 1				v 1
Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: REVIEWED BY: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician Physician			Dioou				I		0
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Other Physicians Who Are Actively Treating You: CARDIOLOGIST: PULMONOLOGIST: Condition: Condition: Condition: DATE: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician		ded:							
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CARDIOLOGIST: PULMONOLOGIST: Condition: Condition: Condition: DATE: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician	Other Physicians Wh	10 Are	Actively '	Treating You:					
PULMONOLOGIST: Condition: DATE: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician	_		v	0	Co	ondition:			
REVIEWED BY: If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician					Co	ondition:			
If this form was filled out more than 30 days ago patient and physician will review and update: Patient Signature: Physician					-				
physician will review and update: Patient Signature: Physician	REVIEWED BY: DATE:								
physician will review and update: Patient Signature: Physician	If this form	was	fille	d out more	th	an 30 days	ago	patie.	nt and
Patient Signature: Physician						_			
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Bighacuic. Date. Date. Date onanges D changes made.	signature:			Date:			No ch	anges C	Changes made.
Physician Signature	Dhysisian Cianatura								



Financial Responsibility for Services

Gregg Polidori, MD, FACP, FACG Robert H. Goo, MD, FACP, FACG Sung K. Yang, MD Sami Akkary, MD, FACG Alexander Stojanovic, MD Dorene Hardie, RN, MSN, NP

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Patient Name:
DOB:
This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. It is YOUR responsibility to obtain any HMO referrals or know your innetwork coverage, please contact your insurance carrier if you have any questions. You will need to contact your primary care physician for any HMO referrals. If you are unable to obtain the referral at that time, you will have to reschedule. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to pay the full balance. All copays and balances will be collected at the time of service. Balances older than 90 days will be collected PRIOR to seeing the doctor.
ACKNOWLEDGEMENT:
I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.
Patient Signature:
Date:
Authorized Representative Signature:
Date:

**How May I Pay? We accept payment by cash, check, VISA, MasterCard, and Discover.

www.oaklandgastroassoc.com _



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CANCELLATION/NO SHOW POLICY

In order to provide quality care, we have implemented an appointment cancellation policy. We ask for courtesy by calling the office, promptly, if you are unable to attend, and no later than 24 hours prior to your scheduled appointment time. Appointments are in high demand and early notification will allow others the opportunity to seek timely medical care.

- Effective November 1, 2017, if an appointment is not cancelled 24 hours prior to your appointment, you will be assessed a \$25 fee. This fee is not covered by your insurance company.
- If you miss your appointment without calling to notify the office, the \$25 fee will apply due to a "no show".
- If you are running late to your appointment or arrive 15 minutes past your appointment time, without notification, we will need to reschedule the appointment.
- We understand there may be times when an unforeseen emergency occurs and you may not be able to attend the appointment. Should you experience such extenuating circumstances, please call the appropriate office and speak with the office manager.
- All prior balances must be paid in full before future appointments are scheduled.

I have read and understand the Cancellation/No Show Policy and agree to the

Print Name	Date	
Signature (Parent/Legal Guardian)	Date	

www.oaklandgastroassoc.com

terms.