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

Diplomates American Board of
Internal Medicine & Gastroenterology

Appointment date:_____
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.

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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* *Race*_____ *Language spoken*_____

*e-mail address:*_____

*Referring Physician:*_____ *Phone:*_____

*Primary Physician:*_____ *Phone:*_____

*Spouse's Name:*_____ *Date of Birth:*_____

*Emergency Contact:*_____ *Phone:*_____ *Relation:*_____

Are you: Employed Full Time/ Part Time/ Not Employed/ Self Employed/ Retired/ Active Duty/ Student

*Is this a Workman's Comp or Auto Insurance 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)_____ ***Signature***_____

Parent/Guardian (if under 18y/a)_____ ***Date***_____

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 information 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_____ **Sex: F M** **DOB**_____ **Age**_____ **Date** _____

Marital status: Single_____ Married____ Divorced____ Widowed_____ Number of Children_____

Physician: (Please circle) **POLIDORI GOO YANG AKKARY STOJANOVIC**

Primary Care Physician_____ **HEIGHT**_____**WEIGHT**_____

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 AND MEDICAL HISTORY—(Circle Yes or NO) If yes, Date of onset, AND where performed.

MEDICAL HISTORY	YES	NO	Onset, Comments
Anorexia / Bulemia	Yes	No	
Arthritis / Joint swelling	Yes	No	
Asthma	Yes	No	
Bleeding disorder	Yes	No	
Blood or infectious disease	Yes	No	
Cancer, Type:	Yes	No	WHEN? WHERE?
Colon polyps	Yes	No	WHEN? WHERE?
Crohn's disease	Yes	No	WHEN? WHERE?
Diabetes	Yes	No	
Epilepsy / seizures	Yes	No	
Gallstones	Yes	No	
Glaucoma	Yes	No	
Headaches/ fainting/ dizziness	Yes	No	
Heart problems/ Chest pain	Yes	No	WHEN? WHERE?
Hepatitis / Liver problems	Yes	No	
Hiatal hernia / GERD	Yes	No	WHEN? WHERE?
High / low Blood pressure	Yes	No	
Kidney disease	Yes	No	
Lung Disease	Yes	No	
Pacemaker / Internal defibrillator	Yes	No	
Sleep Apnea	Yes	No	
Stomach problems / ulcers	Yes	No	
Stroke	Yes	No	
Thyroid problems	Yes	No	
Tuberculosis	Yes	No	
Ulcerative Colitis	Yes	No	

SURGICAL HISTORY	YES	NO	Date, Comments
Colon	Yes	No	WHEN? WHERE?
Stomach	Yes	No	WHEN? WHERE?
Heart:	Yes	No	WHEN? WHERE?
Stent / Bypass	Yes	No	WHEN? WHERE?
Valve	Yes	No	WHEN? WHERE?
Pacemaker	Yes	No	WHEN? WHERE?
Defibrillator	Yes	No	WHEN? WHERE?
Joint replacement	Yes	No	WHEN? WHERE?
Gallbladder	Yes	No	
Hysterectomy	Yes	No	
Appendix	Yes	No	
Prostate	Yes	No	
Bladder	Yes	No	
C-section	Yes	No	
Breast	Yes	No	
Other surgeries			
Other surgeries			
Other surgeries			
Other surgeries			
Anesthesia Problems	Yes	No	
Previous EGD	Yes	No	WHEN? WHERE?
Prev Colonoscopy	Yes	No	WHEN? WHERE?

Vaccinations (yes or No, and date)			
Hepatitis A	Yes	No	
Hepatitis B	Yes	No	

Other

Other

***** Preferred Pharmacy and Phone Number*** :

****ALL CURRENT MEDICATIONS: ***Please include all vitamins, herbs, and pain relievers AND RECENT ANTIBIOTICS**

Medication	Dosage	Times per day	Medication	Dosage	Times per day

****ALLERGIES**	**REACTION**	**ALLERGIES**	**REACTION**	**ALLERGIES**	**REACTION**

➢ **IF YOU HAVE NO ALLERGIES, PLEASE MARK NONE.**

Name_____ **Sex: F M DOB**_____ **Age**_____ **Date**_____

SOCIAL HISTORY: (Past or Current)				
Alcohol	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	What time do you stop eating at night?_____What time do you go to bed?_____	
Do you exercise?	Yes	No	How much?	

FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.			Who?
Alcoholism	Yes	No	
Cirrhosis / Jaundice	Yes	No	
Colon Cancer	Yes	No	AT WHAT AGE DIAGNOSED?
Colon or rectal polyps	Yes	No	
Crohn's/Ulcerative Colitis	Yes	No	
Diabetes	Yes	No	
Gallstones	Yes	No	
Hemachromatosis	Yes	No	
Heart disease	Yes	No	
High Blood Pressure	Yes	No	
Liver Disease	Yes	No	

SYMPTOM REVIEW Check (☒) symptoms you have had in the **past 3 months**

☐ Weight Loss	☐ Cough	☐ Frequent urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor vision/double vision	☐ Heart burn	☐ Difficulty urinating	☐ Anxiety
☐ Dry mouth	☐ Nausea / vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold sensitivity
☐ Hearing loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal congestion	☐ Abdominal pain	☐ New or chronic rash	☐ 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:

Physician notes if needed:

_____

_____

_____

Other Physicians Who Are Actively Treating You:	
CARDIOLOGIST:	Condition:
PULMONOLOGIST:	Condition:

REVIEWED BY: **DATE:**

If this form was filled out more than 30 days ago patient and physician will review and update:

Patient Signature:

signature: *Date:* *Physician* ☐ *No changes* ☐ *Changes made.*

Physician Signature

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Financial Responsibility for Services

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 in-network 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: _____

<u>How May I Pay?</u> We accept payment by cash, check, VISA, MasterCard, and Discover.

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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 terms.

_____ _____

Print Name Date

_____ _____

Signature (Parent/Legal Guardian) Date