



capitahealth

SPECIALIST INFORMATION

Please list your primary care physician as well as any specialist information below in the subsequent sections such as cardiologist (heart doctor), rheumatologist (arthritis doctor), endocrinologist (diabetes doctor), neurologist (stroke or MS doctor), etc... This way we can keep all of your physicians informed about your health. This form will be updated EVERY year and we will ask for your signature verifying our records are correct. Thank you in advance for your anticipated cooperation.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #1: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #2: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #3: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Continue 

Patient Signature & Initials \_\_\_\_\_ Date: \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Specialist #4: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #5: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #6: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #7: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #8: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Specialist #9: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tele: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Name

MRN

DATE

Capital Health Gastroenterology Specialists

New Patient Encounter Form

**HISTORY – COMPLETED BY PATIENT, STAFF, OR PROVIDER**

Please fill this form to your best ability.

1. Reasons for your visit today: \_\_\_\_\_  
\_\_\_\_\_

2. Medical History: Please check all that apply

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Colon cancer or Polyp | <input type="checkbox"/> Heart attack or angina     | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Pancreatitis          | <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Esophageal Cancer     | <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Asthma or Lung Disease |
| <input type="checkbox"/> Pancreas Cancer       | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Barrett's Esophagus   | <input type="checkbox"/> Elevated cholesterol       | <input type="checkbox"/> Bleeding tendency      |
| <input type="checkbox"/> GERD or heartburn     | <input type="checkbox"/> Blood Clot in leg or lung  |   |

Other Gastrointestinal diseases, please specify \_\_\_\_\_  
\_\_\_\_\_

Other, please list: \_\_\_\_\_  
\_\_\_\_\_

3. Please list ALL medication(s) (drugs, pills) you are taking, including dosage and frequency:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Previous Surgeries/Dates: Please check all that apply and list the date(s) to your best recollection

- |  |   |
|--|---|
| <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Esophagus or Stomach _____ |
| <input type="checkbox"/> Colon _____       | <input type="checkbox"/> Pancreas _____             |

Name

MRN

DATE

(Previous Surgeries/Dates, continued)

- Heart bypass surgery \_\_\_\_\_  Other (please list) \_\_\_\_\_  
 Heart Valve Surgery \_\_\_\_\_  
 Hysterectomy \_\_\_\_\_

5. Allergies: Are you allergic to any medication(s)? No  Yes  If yes, please list the medications you are allergic to and the type of reaction \_\_\_\_\_

Are you allergic to any food(s)? NO  YES  Please list: \_\_\_\_\_

6. What is your social history?

Marital Status: Single , Divorced , Married , Widow/Widower , With whom do you live? \_\_\_\_\_

Current occupation/Employer \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_ per month? \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Do you use illicit drugs? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

7. What is the health status of your family?

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_

Family Illnesses:

History of Colon Cancer? No  Yes , Pancreatic cancer? No  Yes

Other cancer? No  Yes  site \_\_\_\_\_

Name

MRN

DATE

8. Review of systems: Do you have signs or symptoms in any of the following areas? Please check the appropriate box.

Yes	No		Yes	No	
		<b><u>Constitutional</u></b>			<b><u>Cardiovascular</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Fever, sweats or chills	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue, anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss >5lbs.	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the ankles
			<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing upon lying down
		<b><u>Skin:</u></b>			<b><u>Respiratory</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice			
		<b><u>Eyes:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes or eye irritation	<input type="checkbox"/>	<input type="checkbox"/>	Sputum production
<input type="checkbox"/>	<input type="checkbox"/>	Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Snoring
			<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth, mouth ulcers
			<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
		<b><u>Ears, Nose, Mouth and Throat:</u></b>			<b><u>Psychiatric:</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Nose, sinus problems			History of anxiety disorder or depression
<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
		<b><u>Gastrointestinal</u></b>			<b><u>Neurological</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or indigestion			Headache
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Focal weakness or numbness
<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, faintness
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
		<b><u>Genitourinary</u></b>			<b><u>Musculoskeletal</u></b>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent, difficult or painful urination			Muscle aches
<input type="checkbox"/>	<input type="checkbox"/>	Nocturia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or arthralgias
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual periods or vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Urethra or vaginal discharge			

Physician Comments – Review of Systems

**Other Symptoms: Please list**

I have personally reviewed the information recorded in the above three pages

Attending Signature \_\_\_\_\_

Date \_\_\_\_\_

**CAPITAL HEALTH SYSTEM**  
**ACKNOWLEDGEMENT OF RECEIPT**  
**NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge that I have received a copy of Capital Health System's Joint Notice of Privacy Practices.

\_\_\_\_\_  
(sign name)

\_\_\_\_\_  
(date)

**Living Will:**

Do you have a Living Will or Power of Attorney?      YES    NO

If YES, please furnish us with a copy of your medical chart or allow us to make a copy to attach to your chart. Thank you.

If NO, would you like more information regarding this subject?      YES    NO

**Contact Information:**

When we need to contact you about test results, prescription refills, referrals, etc. can we leave a message on your:

**Home numbers:** \_\_\_\_\_

**Cell numbers:** \_\_\_\_\_

Gastroenterology Specialists has permission to speak to the following on my behalf: \_\_\_\_\_

**(family member or friend)**

I \_\_\_\_\_ agree to the above.

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CAPITAL HEALTH  
GASTROENTEROLOGY  
1445 WHITEHORSE-MERCERVILLE ROAD  
SUITE 108  
HAMILTON, NJ 08619**

### **Medication History & Medication Benefits Consent**

I give permission for Capital Health Gastroenterology to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health Gastroenterology.

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**Patient Signature and Date**

**General & Financial Consent: Capital Health Medical Group**

**Consent for Treatment:**

I consent to be treated by Capital Health Medical Group under the care of my physician and/or psychotherapist, his/her s and designees. I consent to the care which encompasses routine laboratory, diagnostic, medical/surgical, and/or psychot advisable during treatment. I agree to allow medical, psychology, social work, and nursing trainees, under the supervision and direction of a physician or other licensed provider, to observe my treatment and review my medical record. I understand no guarantees have been made to me about the outcome of this care. I acknowledge Capital Health has the authority to dispose of specimens taken for laboratory and pathology examination.

\_\_\_\_\_  
**Signature** of Patient or Authorized Person (Address/Relationship)

\_\_\_\_\_  
DATE/TIME

**Financial Agreement:**

I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of Capital Health Medical Group in accordance with the regular rates and terms of the group. I intend to be legally bound, assume full responsibility for and agree to pay Capital Health upon presentation of the bill, all expenses and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

**Medicare Authorization for Information and Payment Request Release:**

I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Medical Group for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

**Release of Information:**

I assign benefits payable for physicians' services to the physician or provider furnishing services and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health Medical Group is required by various governmental agencies to review and release patient information. Capital Health Medical Group also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information. I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during my treatment may be retained, preserved, used for teaching purposes, or disposed of by Capital Health Medical Group.

**Consent to Release Medical Records:**

I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up care, this includes designated Care Giver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment and or HIV information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and/or HIV/AIDS diagnosis, treatment or testing. I may revoke this authorization as it relates to Specially Protected Health information by providing written notice to Capital Health Medical Group.

**Consent for Blood Test:**

In the event a physician, employee, worker or student is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I consent to having my blood tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS). Such testing will allow any necessary treatment of the physician, employee, worker or student to begin without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker or student or as required by law or as agreed to by me.

\_\_\_\_\_  
**Signature** of Patient or Authorized Person (Address/Relationship)

\_\_\_\_\_  
DATE/TIME

**Acknowledgment of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy.**

\_\_\_\_\_  
**Signature** of Patient or Authorized Person (Address/Relationship)

\_\_\_\_\_  
DATE/TIME





**capitahealth**  
MEDICAL GROUP

## **Missed Appointment Policy**

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

### **Cancellation of an Appointment**

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

### **How to Cancel Your Appointment**

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

**Late Cancellations:** A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

**No Show Policy:** A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

### **Missed Appointment Fees**

- Patient who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and Subsequent missed appointments: **\$25 fee billed to your account**
- Third missed appointment: **Possible discharged from our practice**

Patient Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**capitahealth**

*Minds Advancing Medicine*

Capital Health Gastroenterology Specialists  
1401 Whitehorse Mercerville Rd, Suite 220A

Hamilton, NJ 08619

Phone #: (609) 528-8884

Fax #: (609) 528-8886

**Medical Records Release**

I, \_\_\_\_\_ authorize the release of my medical records to Capital Health Gastroenterology Specialists.

Please fax all records to 609-528-8886.

Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*Modified 9/7/16*