David E. Wexler, M.D., F.A.C.G., LLC (Drs. Wexler & Shrensel) **Patient Information**

Name: **Date of birth** **Age:** **Date:**

Street Address: **City, State, Zip**

Phone numbers (home) **(work)** **(cell)**

Social Security # **Employer:**

Email address: **If under 18 yrs old name of parent/guardian**

Spouse's name: **Spouse's date of birth:**

Emergency contact other than spouse: (name) **Phone #:**

Referred by: (primary) ***OR*** **(other specialist)**

Symptoms for which you are presenting to this office *(check all that apply)*

☐ Loss of appetite	☐ Rectal bleeding	☐ Weight loss
☐ Inability to tolerate food	☐ Anal pain	☐ Weight gain
☐ Belching	☐ Bloody stool	☐ Itching
☐ Heartburn	☐ Mucus in the stool	☐ Jaundice
☐ Persistent nausea	☐ Black stool	☐ Dark urine
☐ Vomiting ☐ Vomiting blood	☐ Incomplete defecation	☐ Blood transfusions
☐ Bloating	☐ Constipation	☐ Laxative use? ☐ Enema use?
☐ Difficulty swallowing ☐ liquids ☐ solids ☐ both	☐ Diarrhea ☐ at night? How often?	☐ Colon screening

☐Abdominal pain
Where _____

How often _____

What makes it better? _____

What makes it worse? _____

Medical History *Check all that apply to you **include** the approximate **year** diagnosed*

	Yr.		Yr.		Yr.		Yr.
☐ Anemia		☐ Hemorrhoids		☐ Hernia		☐ Thyroid disease	
☐ Ulcerative Colitis		☐ Colon polyps		☐ Hepatitis		☐ Myocardial infarction	
☐ Crohn's		☐ Rectal polyps		☐ Peptic ulcer		☐ Congestive heart disease	
☐ Diverticulosis		☐ Fissures		☐ Gallstones		☐ Valvular heart disease	
☐ Pancreatitis		☐ Fistulas		☐ Diabetes		☐ Rheumatic heart disease	
☐ Varicose veins		☐ Asthma		☐ Psoriasis		☐ Tuberculosis	
☐ Osteoporosis		☐ Hypertension		☐ Stroke			

☐**Cancer**
What kind? ☐Rectal ☐ colon ☐ Esophageal ☐ stomach ☐ gallbladder ☐ prostate ☐ Other _____
Treatment? ☐ Chemotherapy ☐ Radiation ☐ Surgery

Surgery? ☐ Stomach ☐ abdominal ☐ gynecological ☐Colon ☐ Hernia
☐ Other – what type _____ when? _____

Hospitalizations (not including pregnancies)			
Year	**Reason**	**Year**	**Reason**

Females: (Males please continue with next section)
Menstrual flow: ☐ Regular ☐ Irregular ☐ Menopause – what year? _____

Date of 1st day of last period _____

# of pregnancies _____ Abortions _____ Miscarriages _____ Live births _____ C- sections _____

Do you drink: ☐ coffee ☐ tea _____ cups per day ☐ Alcohol _____ oz. per week

Do you smoke? ☐ No ☐ Yes ———Quantity Year you quit (if applicable) ———

Any history ofdrug/substance abuse ☐ Yes ☐ No what? _____ How long? _____

Other symptoms: (*that <u>you</u> may be experiencing*)

☐ Headaches	☐ Hoarseness	☐ Palpitations	☐ Partial paralysis
☐ Poor hearing	☐ Vertigo	☐ Arthritis	☐ Leg pain when walking
☐ Ringing in the ear	☐ Dizzy spells	☐ Back pain	☐ Seizures
☐ Vision changes	☐ Fever	☐ Black outs	☐ Swollen ankles
☐ Poor eyesight	☐ Hayfever	☐ Bruise easily	☐ Tremor
☐ Nasal congestion	☐ Chest pain	☐ Chronic fatigue	☐ Wheezing
☐ Nose bleeds	☐ Pneumonia	☐ Depression	☐ Shortness of breath
☐ Sore throats	☐ Irregular pulse	☐ Difficulty sleeping	☐ At rest
☐ Cough	☐ Heart murmur	☐ Paralysis	☐ on exertion

Family history: *Check all that apply to members of your immediate family (parents, siblings, grandparents)*

	Relative		**Relative**
☐ Celiac disease		☐ Crohn's	
☐ Anemia		☐ Pancreatitis	
☐ Heart disease		☐ Kidney problems	
☐ Peptic ulcer disease		☐ Arthritis	
☐ Hypertension		☐ Liver disease	
☐ Ulcerative colitis		☐ Hepatitis	
☐ Colitis		☐ Stroke	
☐ Diabetes		☐ Gout	
☐ Tuberculosis		☐ Mental illness	
☐ Epilepsy		☐ Colon polyps	
☐ Asthma		☐ Rectal polyps	

☐ **<u>Cancer</u>**: What kind? _____ What age? _____ Which relative? _____

What kind? _____ What age? _____ Which relative? _____

What kind? _____ What age? _____ Which relative? _____

Medications: *List all medications you are currently taking.*

Allergies (include allergies to medications)

DAVID E. WEXLER, M.D., F.A.C.G., LLC
DRS. DAVID E. WEXLER & JEFFREY SHRENSEL
GASTROENTEROLOGY & HEPATOLOGY
DIPLOMAT AMERICAN BOARD OF INTERNAL MEDICINE SUBSPECIALTY GASTROENTEROLOGY

727 RARITAN ROAD, SUITE 101, CLARK, NEW JERSEY 07066
(732) 499-8000 FAX (732) 396-9413

CANCELLATION POLICY

Dear Patient:

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with David E. Wexler, MD, FACG, LLC. We are always dedicated to the quality of care for all our patients. Our office cancellation policies are as follows. Please read carefully and sign below.

General Office Cancellation Polices

1. We require at least **24- hours** notice in the event of a cancellation for **office** appointments and **48** to **72 hours** for **procedures**.
2. There is a **$50 charge** for a no-show or cancellation without proper notice for office appointments and **$200 charge** for a no-show or cancellation without proper notice for procedures. This charge will not be covered by your insurance company, but will have to be paid by you personally.
3. You should understand that when you do not keep your scheduled appointment three people get hurt: 1) yourself because you don't get the medical attention you need as prescribed by the doctor. 2) the physician who now has a "vacancy" in the schedule since the time was reserved for you personally, and 3) another patient who could have been given the appointment if you had given us proper notice.

   Thank you for your cooperation and understanding.

After you have read the above carefully, please sign the following:

I, _____, have read the cancellation policy above and understand the terms.

_____ _____

Patient Signature Date

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Prescription Eligibility and information

I, _____ (patient) allow the physician's of David E. Wexler, MD, FACG, LLC to obtain any prescription eligibility and information that is found on the national database to assist in my medical care. I understand that this information will be used for informational purposes and enable the physician to prescribe medications that are within my insurance formulary. I understand Dr. Wexler, Dr. Lesser and Dr. Shrensel will prescribe medications that are in my best interest.

_____ _____

Patient signature **Date**

DAVID E. WEXLER, M.D., F.A.C.G., LLC
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Acknowledgement Receipt of Privacy Notice

I have been informed that the office of David E. Wexler, M.D., F.A.C.G., LLC., has prepared a Privacy Notice ("**Notice**") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying the office, in writing, but if I revoke my consent, such revocation will not affect any actions that physicians employed by David E. Wexler, M.D., F.A.C.G., LLC., took before receiving my revocation.

I understand that David E. Wexler, M.D., F.A.C.G., LLC., has reserved the right to change the Privacy Practices and that I can obtain such changed notice upon request.

I understand that I have the right to request the office of David E. Wexler, M.D., F.A.C.G., LLC, restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the office does not have to agree to such restrictions, but that once such restrictions are agreed to, they must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**

_____

Printed name of patient or patient's representative

_____

Relationship to the patient if signed by a representative

Insurance Authorization & Assignment

I hereby authorize and direct any holder of medical information about me to release to the Health Care Financing and Administration and its agents and/or any other insurance carrier any information needed to determine these benefits or the benefits payable for related services. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits and for services and for my insurance carrier to pay directly to David E. Wexler, M.D., F.A.C.G. LLC for medical services rendered to myself or my dependent under my insurance plan. I understand that I am responsible for any amount not covered by my insurance. It is not necessary to obtain my signature on each and every claim to be submitted for my dependents or myself. I authorize this signature as though the undersigned had personally signed the particular claim. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of patient or patient's representative **Date**

_____

Printed name of patient or patient's representative

_____

Relationship to the patient if signed by a representative

***Race:**	**Asian**	***Language:**	**English**	***Ethnicity:**	**Hispanic**
	Native Hawaiian		**Other**		**Non-Hispanic**
	Black or African American		**Russian**		
	White		**Spanish**		
	Hispanic		**Indian (Including Hindi & Tamil)**		
	Other Race				

***Please circle your response**

Pharmacy Information: **Name:** _____ **Phone:** _____

Address: _____

Prescription Card ID Number: _____

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Contact Authorization

Patient confidentiality is a prime concern in our office. Please indicate below with whom our office can or cannot leave a message. It is our policy to call you to confirm your scheduled appointment/procedure, to obtain protected health information in order to process claims on your behalf or when returning calls in reference to test results.

Can we call you and/or leave a telephone message for you at home? ☐ YES ☐ NO
Are you able to receive calls at your place of business? ☐ YES ☐ NO
If yes, are we able to state who and from where we are calling? ☐ YES ☐ NO
Can we send mail to you at your home address? ☐ YES ☐ NO
Can we leave messages with a family member or significant other? ☐ YES ☐ NO

Due to the Privacy Rule, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have your permission.

	Yes	NO	Telephone #	N/A
Spouse	☐	☐		☐
Children	☐	☐		☐
Other	☐	☐		☐
EMAIL			Email address	
	☐	☐		☐

Please provide the names of those individuals we have permission to speak to about your Protected Health Information:

Name: **Relationship**:

Name: **Relationship**:

Name: **Relationship**:

Are there individuals to whom you specifically DO NOT want us to reveal any of your Protected Health Information?

Name:

Name:

Name:

Please list all the physicians that you see and would like copies of your reports sent:

Signature: **Date**:

From the office of DAVID E. WEXLER, M.D., F.A.C.G., A.G.A.F.
727 RARITAN ROAD, SUITE 101, CLARK NEW JERSEY 07066 TELEPHONE # (732) 499-8000 FAX # (732) 396-9413

Authorization for Release of Information to Drs. Wexler & Shrensel

SECTION A: ***Must be completed for ALL authorizations***

I hereby authorize the use or disclosure of my individually identifiable health information (which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment and health care operations) as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: **Date of Birth:**

In the event that you want any of your Protected Health Information sent to another organization (i.e. insurance company for application of health or life benefits, lawyers' offices, etc.), you must complete the following:

Organization providing the information	**Organization receiving the information**

Clearly specify which information (including date(s) of healthcare) to be disclosed:

SECTION B: ***Must be completed ONLY if a health plan or health care provider has requested the authorization.***

1. The health plan or health care provider must complete the following:
   a) What is the purpose of the use or disclosure?
      GI EVALUATION

   b) Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?
      ☐ YES ☒ NO
2. The patient or the patient's representative must read and initial the following statements:
   a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
      Initials: _____

   b) I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
      Initials: _____

SECTION C: ***Must be completed for ALL authorizations:***

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____/ _____/ _____
   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation.
   Initials: _____

Signature of patient or patient's representative **Date**
(This form MUST be completed before signing)

Printed name of patient or representative: **Relationship to patient**