

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)

<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Inability to tolerate food	<input type="checkbox"/> Anal pain	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Belching	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Itching
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Mucus in the stool	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Persistent nausea	<input type="checkbox"/> Black stool	<input type="checkbox"/> Dark urine
<input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Incomplete defecation	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Bloating	<input type="checkbox"/> Constipation	<input type="checkbox"/> Laxative use? <input type="checkbox"/> Enema use?
<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> liquids <input type="checkbox"/> solids <input type="checkbox"/> both	<input type="checkbox"/> Diarrhea <input type="checkbox"/> at night? How often? _____	<input type="checkbox"/> 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.
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Hernia		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Ulcerative Colitis		<input type="checkbox"/> Colon polyps		<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Myocardial infarction	
<input type="checkbox"/> Crohn's		<input type="checkbox"/> Rectal polyps		<input type="checkbox"/> Peptic ulcer		<input type="checkbox"/> Congestive heart disease	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Fissures		<input type="checkbox"/> Gallstones		<input type="checkbox"/> Valvular heart disease	
<input type="checkbox"/> Pancreatitis		<input type="checkbox"/> Fistulas		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Rheumatic heart disease	
<input type="checkbox"/> Varicose veins		<input type="checkbox"/> Asthma		<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Hypertension		<input type="checkbox"/> 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 of drug/substance abuse Yes No what? _____ How long? _____

Other symptoms: (that you may be experiencing)

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

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

	Relative		Relative
<input type="checkbox"/> Celiac disease		<input type="checkbox"/> Crohn's	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Pancreatitis	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> Peptic ulcer disease		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Ulcerative colitis		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Colitis		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Gout	
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Mental illness	
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Colon polyps	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Rectal polyps	

Cancer: 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

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	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
EMAIL			Email address	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

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:** _____

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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 Policies

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