

# Digestive Disorders Associates

## Gastroenterology

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Lisa Medeiros, CRNP

Rebecca Turner, CRNP

### Main Offices

621 Ridgely Avenue, Suite 201

Annapolis, Maryland 21401

410-224-4887

Fax 410-224-1428



1630 Main Street

Suite 204

Chester, Maryland 21619

Dear Patient:

We at Digestive Disorders Associates welcome you, and are pleased to join your primary care physicians in assisting with your health care needs. To introduce you to our practice we have enclosed a brochure, which addresses some of the questions many patients have. We have also included directions to our offices.

To help acquaint us with your medical history we ask that you complete and bring along the enclosed history and physical questionnaire. Please bring any recent tests that pertain to your appointment. This important information enables us to complete a thorough and efficient consultation.

Your appointment has been scheduled for \_\_\_\_\_ at \_\_\_\_\_. Please arrive at least 20 minutes early. If you have any questions or concerns, please feel free to call our office. If you need to cancel your appointment, please contact the office at least 24 hours in advance, 410-224-4887.

We look forward to meeting you.

Sincerely,

Michael S. Epstein, M.D.

Charles E. King, M.D.

Ritu M. Sachdev, M.D.

Barry J. Cukor, M.D.

Vishnupriya Krishna, M.D.

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Lisa Medeiros, CRNP

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### PLEASE BRING TO YOUR APPOINTMENT

- Insurance Card
- Picture ID
- Co-pay listed for specialist
- Completed forms
- Valid referral from PCP (if required)
- Pertinent medical records

We accept cash, checks, Visa or Mastercard for payment.  
Your co-payment, if required, is due at the time of service.

Kindly give 24 hours notice if you are unable to keep your appointment. This will enable you to avoid our \$50.00 no-show fee.

Thank You

# DIRECTIONS TO THE OFFICES OF DIGESTIVE DISORDERS ASSOCIATES

**ANNAPOLIS OFFICE**  
**RIDGELY OAKS PROFESSIONAL CENTER**  
621 RIDGELY AVENUE, SUITE 201  
ANNAPOLIS, MD 21401

**FROM BALTIMORE:**

- I-695 SOUTH, EXIT I-97 SOUTH
  - I-97 TO ROUTE 50 EAST
  - THEN FOLLOW ROUTE 50 EAST
- DIRECTIONS LISTED BELOW

**FROM ROUTE 50 EAST:**

- TAKE EXIT 24-ROWE BLVD/BESTGATE RD
- TURN LEFT ONTO BESTGATE RD
- AT FIRST LIGHT, TURN RIGHT ONTO N. BESTGATE RD
- GO TO STOP SIGN AND TURN RIGHT ONTO RIDGELY AVENUE
- RIDGELY OAKS IS APPROXIMATELY ¼ MILE ON THE RIGHT

**FROM ROUTE 50 WEST:**

- TAKE EXIT 24B-BESTGATE RD
- AT FIRST LIGHT, TURN RIGHT ONTO N BESTGATE RD
- GO TO STOP SIGN & TURN RIGHT ONTO RIDGELY AVENUE
- RIDGELY OAKS IS APPROXIMATELY ¼ MILE ON THE RIGHT

**FROM DOWNTOWN ANNAPOLIS:**

- FOLLOW ROWE BLVD TO THE 2<sup>ND</sup> LIGHT
- TURN RIGHT ONTO MELVIN AVENUE
- GO TO STOP LIGHT & TURN LEFT ONTO RIDGELY AVENUE
- RIDGELY OAKS IS APPROXIMATELY 1 MILE ON THE LEFT

**ODENTON OFFICE**  
**WINMARK ONE BUILDING**  
1130 ANNAPOLIS ROAD, SUITE 105  
ODENTON, MD 21113

**FROM ROUTE US-50**

TAKE EXIT 21-(I-97N)  
EXIT 7- (MD-32W) TOWARD  
COLUMBIA  
TAKE BURNS CROSSING RD. EXIT  
AT TRAFFIC CIRCLE, TAKE FIRST EXIT  
ONTO ANNAPOLIS RD.  
FACILITY LOCATED ON RIGHT

**FROM ROUTE I-95/295**

TAKE EXIT 38-(FT. MEADE) ONTO TAKE  
MD-32  
TAKE EXIT 6- ONTO ANNAPOLIS RD.  
TOWARD ODENTON  
FACILITY LOCATED ON LEFT

**CHESTER OFFICE**  
**ANNE ARUNDEL MEDICAL CENTER - KENT ISLAND FACILITY**  
1630 MAIN STREET, SUITE 204  
CHESTER, MD 21619

**FROM ROUTE 50 EAST:**

- TAKE EXIT 39B-DOMINION RD
- TAKE RIGHT ONTO DOMINION RD
- TURN RIGHT ONTO MAIN ST
- FACILITY LOCATED NEXT TO FIRE STATION

**FROM ROUTE 50 WEST:**

- TAKE EXIT 39A-CASTLE MARINA RD
- TAKE RIGHT ONTO CASTLE MARINA RD
- ENTER THE ROUNDABOUT & TAKE THE FIRST EXIT ONTO MD 18-MAIN ST
- FACILITY LOCATED NEXT TO FIRE STATION

## OFFICE POLICY AND PROCEDURES

1. **REFERRALS** – Patients must present Valid Referral (if required) at the time of service or the visit must be paid in full or rescheduled. We do not contact primary care physicians for referrals. Please make sure your referral is dated, the referring physician or facility name is correct, the place of service is marked as office, and that the referral has not expired. If you are unsure of expiration date, PLEASE verify with primary care physician and have them mark this. (It is the patient's responsibility to obtain a copy of the referral for their records).
2. **CANCELLATIONS** - Our office requires a 24-hour notice for cancellation. If an appointment is not cancelled, the patient is charged a no-show fee of \$50.00. If you believe you were charged this no-show fee in error, we allow 30 days to dispute this charge. This amount will be due prior to the patient's next visit.
3. **MEDICAL RECORDS** – Medical Records request require 5 to 10 business days to process. There is a fee for this processing mandated by Maryland State Law. This fee is \$20.00 plus an additional \$0.68 per page for **physician transfers**. For **patient personal use** there is a fee of \$0.68 per page ONLY. **Pre payment is required and patient pickup is recommended.**
4. **CO-PAYMENTS** – Co-payments **must** be paid at the time of service. This is required in the terms of your contract with your insurance company. There is a \$5.00 service fee for non payment of your copay. Any amounts that are applied to the patient's deductible are due and payable prior to the patient's next visit or within 30 days after we receive notification from your insurance company, whichever comes first. If you are unable to make these payments, arrangements may be made with our billing department prior to your next visit.
5. **INSURANCE** – Patients must present appropriate insurance information at the time of service or the visit must be paid in full or rescheduled. If your card does not have appropriate information listed, you will be responsible for your visit.
6. **PRESCRIPTIONS** – Prescription refills and prior authorizations require 72 hours notice to be filled. Detailed information must be left in order for this process to be completed.
7. Patients who hold Medical Assistance are required to pick up and hand carry all prescriptions to the pharmacy for processing.

I authorize release of my medical records to my insurance company, if necessary, to process my claim. I understand that this authorization may be revoked by me, in writing, at anytime.

I authorize Digestive Disorders Associates to obtain medical records relating to my care from previous providers of service.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Responsible Party (Please Print)

**Digestive Disorders Associates**

PATIENT NAME: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

Please complete this form regarding any tests or procedures you have already **had done** in regards to the reason for your visit today. You must also contact the Doctor or Facility where the test(s) were done and **bring copies of your records to your appointment** with you, if you don't have the records it may **delay** you being seen in a timely fashion.

Have you had any recent testings done (regarding your visit today) within the last 6 months to a year? (Please circle one)

YES                      NO

**IF YES,**

WHAT TYPE: (Please check all that apply)

\_\_\_\_ Radiology/X-ray

\_\_\_\_ Laboratory Test/Bloodwork

\_\_\_\_ Hospitalizations

\_\_\_\_ Other Diagnostic Test/Procedures

WHEN & WHERE:

Test Name(s) & Date(s): \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Testing Location: \_\_\_\_\_

Test Name(s) & Date(s): \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Testing Location: \_\_\_\_\_

Test Name(s) & Date(s): \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Testing Location: \_\_\_\_\_

**Please use extra sheets of paper, if needed.**

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

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

SSN: \_\_\_\_\_

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

Referring Physician: \_\_\_\_\_

**Current Medications (List All):**

Medication	Dose (MGM)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Office Use ONLY:**

Temp \_\_\_\_\_

HP \_\_\_\_\_

P \_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

RR \_\_\_\_\_

# Digestive Disorders Associates

Allergies:			
<input type="checkbox"/>	None	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	Morphine	<input type="checkbox"/>	Demerol
<input type="checkbox"/>	Versed	<input type="checkbox"/>	Valium
<input type="checkbox"/>	Other:		

Past Medical Illness General:			
<input type="checkbox"/>	NONE	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Colon Polyps	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Other:		

Past Medical Illness Cancer:			
<input type="checkbox"/>	None	<input type="checkbox"/>	Colon
<input type="checkbox"/>	Esophageal	<input type="checkbox"/>	Liver
<input type="checkbox"/>	Breast	<input type="checkbox"/>	Prostate
<input type="checkbox"/>	Other:		

Past Medical Illness Gastrointestinal:			
<input type="checkbox"/>	NONE	<input type="checkbox"/>	Diverticulosis
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	Gall Stones
<input type="checkbox"/>	Reflux	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Other:		

Surgeries/Hospitalizations/Procedures:							
<input type="checkbox"/>	NONE	<input type="checkbox"/>	Colonoscopy	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	Cholecystectomy
<input type="checkbox"/>	Prostate	<input type="checkbox"/>	C-section	<input type="checkbox"/>	Colon Resection	<input type="checkbox"/>	Liver Biopsy
<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	Cardiac Surgery	<input type="checkbox"/>	ERCP	<input type="checkbox"/>	Hiatal Hernia
<input type="checkbox"/>	Other:						

Social History Marital Status:			
<input type="checkbox"/>	Single	<input type="checkbox"/>	Separated
<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Widowed

Social History Recreational Drugs:			
<input type="checkbox"/>	I have never used recreational drugs		<input type="checkbox"/>
<input type="checkbox"/>	I have used recreational drugs in the past		<input type="checkbox"/>

Social History Alcohol:			
<input type="checkbox"/>	Never	<input type="checkbox"/>	More than 2 days/week
<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Less than 2 days/week
<input type="checkbox"/>	Daily	<input type="checkbox"/>	I quit using alcohol

Social History Tobacco:			
<input type="checkbox"/>	I use tobacco products		<input type="checkbox"/>
<input type="checkbox"/>	I quit using tobacco products		<input type="checkbox"/>

Social History Occupation:	
Patient Occupation:	

Social History Hobbies:	
Patient Hobbies:	

## Review of Systems

Gastrointestinal:	
<input type="checkbox"/>	NONE
<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Soiling
<input type="checkbox"/>	Ulcerative colitis
<input type="checkbox"/>	Irritable bowel disease
<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Milk intolerance
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Crohn's disease
<input type="checkbox"/>	Trouble swallowing
<input type="checkbox"/>	Other:

Genitourinary:	
<input type="checkbox"/>	NONE
<input type="checkbox"/>	Frequent urinary infections
<input type="checkbox"/>	Change in urinary frequency
<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Sexual difficulty
<input type="checkbox"/>	Other:
<input type="checkbox"/>	MALE
<input type="checkbox"/>	Testicle problem
<input type="checkbox"/>	FEMALE
<input type="checkbox"/>	Heavy periods
<input type="checkbox"/>	Breast lump

Cardiovascular:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Angina / chest pain w/ activity
<input type="checkbox"/> Pain in legs w/ walking	<input type="checkbox"/> Swelling in legs
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> Other:	

Skin:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Rash	<input type="checkbox"/> Overall itching
<input type="checkbox"/> Nodules	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Psoriasis	<input type="checkbox"/>
<input type="checkbox"/> Other:	

Neurological:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Stroke or paralysis
<input type="checkbox"/> Seizures	<input type="checkbox"/> Chronic numbness/ tingling
<input type="checkbox"/> Weakness in arms	<input type="checkbox"/> Weakness in legs
<input type="checkbox"/> Other:	

Endocrine:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Diabetes taking insulin
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Diabetes taking oral medication
<input type="checkbox"/> Other:	

Constitutional:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Fever
<input type="checkbox"/> Weight stable	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Other:	

Psychiatric:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Bipolar disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> Abnormal sleep
<input type="checkbox"/> Chronic anxiety	<input type="checkbox"/> Memory loss/ confusion
<input type="checkbox"/> Other:	

Eyes:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glasses	<input type="checkbox"/> Inflammation
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Change in vision
<input type="checkbox"/> Other:	

Hematologic:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding doesn't stop easily
<input type="checkbox"/> Frequent bruising	
<input type="checkbox"/> Other:	

Ears, Nose & Throat:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Chronic sinus
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Other:	

Musculoskeletal:	
<input type="checkbox"/> NONE	<input type="checkbox"/> Disc problem
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chronic stiff joints
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Swollen joints
<input type="checkbox"/> Back pain	
<input type="checkbox"/> Other:	

Respiratory:					
<input type="checkbox"/> NONE	<input type="checkbox"/> Asthma / wheezing	<input type="checkbox"/> TB skin test	<input type="checkbox"/> TB	<input type="checkbox"/> Chronic cough	
<input type="checkbox"/> Coughs up blood	<input type="checkbox"/> Chronic airway disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:					

**Family History**

Family History	Father	Mother	Brother	Sister	Grand Parent
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History	Father	Mother	Brother	Sister	Grand Parent
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Profile - VERIFY/COMPLETE THIS FORM IN ITS ENTIRETY**

Doctor: \_\_\_\_\_

**PATIENT INFORMATION**

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

Patient ID #: \_\_\_\_\_ Sex: [ ]M [ ]F

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

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

City,State: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Cell

Marital Status: [ ]Married [ ]Single [ ]Divorced

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Cell

Patient Email: \_\_\_\_\_

May we contact you at Home? Yes/No (Please Circle)

May we contact you at Work? Yes/No

May we leave a message? Yes/No

May we discuss your medical/billing records with your Spouse or other family members? Yes/No

**REFERRING PHYSICIAN INFORMATION**

Referring Physician: \_\_\_\_\_

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

**GUARANTOR INFORMATION**

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

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

City,State: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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

**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_

Pharmacy Fax #: \_\_\_\_\_

**GUARANTOR EMPLOYMENT**

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

**PATIENT EMPLOYMENT**

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

**SECONDARY INSURANCE**

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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

Insured Party Employer: \_\_\_\_\_

Insured Party Employer Phone # \_\_\_\_\_

**PRIMARY INSURANCE**

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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

Insured Party Employer: \_\_\_\_\_

Insured Party Employer Phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

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

Witness : \_\_\_\_\_