

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

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1630 Main Street
Suite 204
Chester, Maryland 21619

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1130 Annapolis Road
Suite 105
Odenton, Maryland 21113

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.

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PLEASE BRING TO YOUR APPOINTMENT

- Insurance Card
- Completed forms
- Picture ID
- Valid referral from PCP (if required)
- CoPay listed for specialist
- 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 2ND 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

1130 ANNAPOLIS ROAD, SUITE 105
ODENTON, MD 21113

FROM ROUTE US-50

TAKE EXIT 21-(I-97N)
(MD-32W) TOWARD
COLUMBIA
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 EXIT 7-
MD-32
TAKE EXIT 6- ONTO ANNAPOLIS RD. TAKE
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 39A-CASTLE MARINA RD
- TAKE RIGHT ONTO DOMINION RD
- TURN RIGHT ONTO MAIN ST
- FACILITY LOCATED NEXT TO FIRE STATION

FROM ROUTE 50 WEST:

- TAKE EXIT 39B-DOMINION 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 a 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 the 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 visit.)
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. Failure to cancel an appointment for a procedure with the MDTEC facility within 48-hours will result in a fee in the amount of \$100.00. 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 \$22.00 plus an additional \$0.73 per page for **physician transfers**. For **patient personal use** there is a fee of \$0.73 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 will be rescheduled. If your card does not have the 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 any time.

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

Patient or Responsible Party Signature

Date

Patients 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 testing 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	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Use ONLY:

Temp _____

HP _____

P _____

Weight _____

Height _____

RR _____

Digestive Disorders Associates

Allergies:		
<input type="checkbox"/> NONE	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Morphine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa
<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"/> Stroke	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Emphysema	<input type="checkbox"/> History of Blood Transfusion
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Other:			

Past Medical Illness, Cancer:		
<input type="checkbox"/> NONE	<input type="checkbox"/> Colon	<input type="checkbox"/> Lung
<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"/> Hepatitis A	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Other Hepatitis
<input type="checkbox"/> Reflux	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hepatitis C	
<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"/> Appendectomy	<input type="checkbox"/> EGD
<input type="checkbox"/> Prostate	<input type="checkbox"/> C-Section	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Liver Biopsy	<input type="checkbox"/> Obesity Surgery	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> ERCP	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Other					

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

Social History: Recreational Drugs	
<input type="checkbox"/> I have never used recreational drugs	<input type="checkbox"/> I am currently using recreational drugs
<input type="checkbox"/> I have used recreational drugs in the past	<input type="checkbox"/> I have been treated for Substance abuse

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"/> I have never used tobacco products
<input type="checkbox"/> I quit using tobacco products	

Social History: Occupation	
Patient Occupation:	

Social History: Hobbies	
Patient Hobbies:	

REVIEW OF SYSTEMS

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

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

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"/> 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"/> 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"/>