SJPEDGI
South Jersey Pediatric Gastroenterology LLC
John Y. Tung, M.D.

Child 1st name: _____ Mid Name: _____Last Name: _____

DOB: _____-_____-_____ Male_____ Female_____ Referring Doctor_____

Address_____City_____State_____ZIP_____

Mom CELL#_____ Dad CELL#: _____HOME#:_____

Legal Guardian EMAIL:_____state relation: _____

Pharmacy: _____Addr_____City_____State_____ZIP_____

Primary Insurance (OR LEGAL GUARDIAN) –Card/legal guardian doc must be available for office to copy.

INS: _____ Policy: _____Ded Amt:_____Co-ins:_____ specialist copay: $_____

Policy Holder/Legal Guardian: 1st Name: _____Last Name: _____ Relation_____

DOB: _____-_____-_____ Male_____ Female_____

Phone: CELL_____ WORK: _____ HOME: _____

Address (if different fr. above)_____City_____State_____ZIP_____

Employer: _____ Address:_____City_____State_____ZIP _____

Secondary Insurance (if available) OR LEGAL GUARDIAN:

INS: _____ Policy: _____Ded Amt:_____Co-ins:_____ specialist copay: $_____

Policy Holder/Legal Guardian: First Name: _____ Last Name: _____ Relation_____

DOB: _____-_____-_____ Male_____ Female_____

Phone: CELL_____ WORK: _____ HOME: _____

Address (if different fr. above) _____City_____State_____ZIP_____

Employer: _____ Address:_____City_____State_____ZIP _____

I am responsible for payments which includes deductibles, co-insurance, unpaid balances, costs incurred by collection services in case of non-payment, including reasonable attorney fees and court costs related to services rendered by SJPEDGI. With dependents of divorced parents, adopted children, state custody children, the person bringing the child is responsible for this payment. It is my responsibility to find out if Dr John Tung is in network with my insurance. I give permission to SJPEDGI to release any information, to appeal on my behalf to the insurance company and authorize assignment of all payments to be paid to SJPEDGI. A photocopy of this document shall be effective and valid as the original.

Signature: Date:

SJPEDGI NEW PATIENT HISTORY FORM

Patient Name _____DOB _____
Person completing form _____ Relation to Patient _____
Can you give consent for medical examination and procedures for this child? Yes No
Pain- Location of pain- right, left, upper, middle_____When did pain start? _____
Severity of pain eg 7/10 _____Sharp or Dull pain?_____ Pain moves anywhere-into back/chest?_____ How often-eg 10x a day, daily, _____ Anything makes pain worse or better?_____ . Related to school/stress/food _____
Anything else?_____
_____
Pooping problem? How often is there a poop-daily?_____Hard or soft?_____
Bloody____Block toilets_____ Did child poop on 1st day of life_____Veg/Fruits in diet_____Water intake enough?_____, Abdominal pain?_____ Abdominal swelling? ____
Dirty Underwear_____ Painful poop_____ Afraid to Poop_____ Potty trained?_____
Anything else? _____
Reflux/VOMIT- vomit frequency per day____ Projectile or wet burps_____ Bloody_____
Bile/green vomiting_____ Unable to breathe with vomiting_____ Turn blue_____
Turn Red_____ Pain/crying with this_____Formula used_____,
Thicken formula with cereal?_____How much cereal?_____ Which cereal_____
Duration of crying per day_____Swallowing problem _____
Anything else? _____
Weight Gain/Loss concern-_____ **Appetite concern-**_____
Feeding problems: _____
Food allergy to milk, eggs, soy, wheat, seafood, nuts?_____
Gas problems?_____ Related to Milk?_____Recent Antibiotic use_____
School problems?: _____ School Absence?_____
Any other problems:_____
_____
_____
_____
Medical tests done so far: _____
_____
Birth Birth Wt ____ Full Term?_____ Medical problems_____
Significant diseases: (eg. asthma, diabetes, autism, heart operations)
_____
_____
Immunization: up to date? _____ **DEVELOPMENT:**Roll over ____ Sit up_____ Walk _____Toilet Train____
ENVIRONMENTAL: TAP/City water_____ Well water_____ Mould_____
Smoke in house_____Pets in house? _____ Travel outside USA _____
MEDICATIONS: give dose and how many times a day medication taken.
_____
_____
******MEDICATION ALLERGY******-_____
SURGERIES and HOSPITALIZATION_____
_____

Review of Systems: (Circle)

General: weight loss without trying, sleepy and tired all the time, chills and night sweats
Blood/Circulation: Fatigue, Bleeding problems, Cold hands/feet
Heart: Fainting, Abnormal hear rate, Chest pains
Lungs: : Wheezing, Coughing, Shortness of breath
Skin: Acne, Psoriasis, Eczema
Endocrine: Diabetes, Growth problems, Overweight
ENT: Hearing loss, Ear infections, hoarseness
Eye: Glasses, Painful eyes, Red eyes
GI: Constipation , Diarrhea, Vomiting
Kidney: infection**,** Wet bed, Bloody urine
Musculoskeletal: Back pain, Stiffness Swollen joints
Neurology: Migraines, Headaches, Seizures Dizzyness
Psych: Suicidal thoughts, Anxiety Hyperactive
Allergies: Rash, Hives, Wheeze

Reviewed by Dr J Tung _____

Family History

Does any family member have a history of any of the following?

Food allergies _____
Anesthesia problems _____
Growth problems _____
Heart disease _____
Lung disease _____
Joint pain _____
Migraines _____
Irritable bowel _____
Chronic diarrhea _____
Constipation _____
GERD _____
Ulcers _____
Abdo pain _____
Ulcerative colitis _____
Crohn's disease _____
Celiac disease _____
Lactose Intolerance
Pancreas disease _____
Gall bladder dis. _____
Liver disease _____
High cholesterol _____

SOCIAL HISTORY (circle or fill in)

Are parents living together? _____
Who does the child live with?
Mother , Father, Stepfather, Stepmother
Childs lives in 2 homes/ parents divorced?_____
How may toilets at home?_____
How many people stay at home_____

School _____ Grade _____
Does child attend daycare? Yes No
What pets do you have?_____

Over 12 years old- do you take (circle)
Recreational drugs
Alcohol
Smoke

Living Will If patient >18 yr, do you have one?
Yes No

Cultural- do you have any language difficulty, disability or special needs required for communication with the doctor or medical staff?
Yes No

Ethnic group: circle
African American, Hispanic, Chinese, Japanese, Korean, Indian, Pakistani, Bangladesh, Middle Eastern, Arab, White/Caucasian, other

Diet: Vegetarian Lactovegan, Standard American

Use this space to add anything you would like me to know in addition to the above:

_____
_____
_____
_____
_____
_____
_____

SJPEDGI
South Jersey Pediatric Gastroenterology LLC
John Y. Tung, M.D.

Medical Record Release Authorization Form

I hereby authorize: _____

Officeaddress: _____

_____

To release all medical records of my child/children to:

South Jersey Pediatric Gastroenterology, LLC.
5429 Harding Highway Suite 302, Mays Landing, NJ 08330
Fax 609-625-4162, telephone 609-625-8688

Patient's's Full Name: _____

Date of birth: _____

Patient's address: _____

_____

Patient's phone number: _____

Parent/Guardian signature: _____

Date: _____