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APPT DATE: _____ APPT TIME: _____ OFFICE LOCATION: WARREN

DEAR PATIENT :

PLEASE FILL OUT THE ENCLOSED FORMS AND RETURN THEM TO OUR OFFICE PRIOR TO YOUR APPOINMENT DATE. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE COMPLETING THE FORMS**, PLEASE CALL US AT 973-467-1313.**

PLEASE BRING YOUR INSURANCE CARD(S), A PHOTO ID AND A LIST OF YOUR MEDICATIONS AND DOSAGES.

IF YOU HAD ANY LAB WORK, EKGS, OR X-RAYS PERFORMED, PLEASE BRING COPIES OF YOUR REPORTS AND/OR FILMS WITH YOU. **FAILURE TO BRING THIS INFORMATION WITH YOU MAY RESULT IN UNNECESSARY DELAYS AT THE TIME OF YOUR APPOINTMENT**.

IF YOU BELONG TO AN HMO, POINT-OF-SERVICE, OR PPO INSURANCE AND A REFERRAL FORM IS REQUIRED TO SEE A SPECIALIST, **PLEASE MAKE SURE TO BRING IT FOR YOUR APPOINMENT** ALONG WITH YOUR REQUIRED COPAY.

WE ACCEPT PAYMENT FOR THE OFFICE VISIT IN THE FORM OF CASH, CHECK, MASTERCARD OR VISA FOR YOUR CONVENIENCE.

THANK YOU FOR YOUR COOPERATION.

ASSOCIATES IN DIGESTIVE DISEASES.