Affiliates in Gastroenterology, P. A.

Today's Date_____

Patient Information

MRN #_____(office use only)

Name: Last_____ First:_____ Middle:_____

Address_____ City,State,Zip_____

How may we contact you? Home Phone: Yes No_____ Cell Phone: Yes No _____

Work Phone: Yes No _____May we leave a message? Home - Yes No, Cell - Yes No, Work - Yes No

Birthdate_____Social Security #_____E-mail_____

Sex: M F Place of Birth_____ Marital Status: Single Married Widow Divorced Separated

Occupation_____ Employer_____

Referring or Family Physician_____

Pharmacy_____ Pharmacy Phone #_____

Emergency Contact Information

Name_____ Phone #_____

Relationship_____ Other Phone #_____

Responsible Party Information, If Other Than Patient

Responsible Party_____ Relationship to Patient_____

Address_____ City,State,Zip_____

Phone #_____ Other Phone #_____

Insurance Information - MUST BE COMPLETED IN ITS ENTIRETY

Primary Insurance_____ Group #_____

Address_____ ID#_____

Subscriber_____ Subscriber's Birthdate_____

Insurance Phone #_____ Do you require a referral from your PCP? Yes No

Employer_____

Secondary Insurance_____ Group #_____

Address_____ ID#_____

Subscriber_____ Subscriber's Birthdate_____

Insurance Phone #_____

Do you require a referral from your PCP?_____

Please complete reverse side of this form. Signatures are required.

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Affiliates in Gastroenterology, P. A. may disclose certain health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Affiliates in Gastroenterology will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I designate the following persons as persons involved with my health care or payment relating to my health care for the purpose of Affiliates in Gastroenterolgy, P. A. making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print name(s) and date of birth_____

_____

_____

The staff and/or physicians of Affiliates in Gastroenterology, P. A. may need to contact you regarding appointments, results of tests, return phone calls, etc.

With whom may we leave a message for you to contact this office? (Please list name and relationship to you)

_____

_____

_____

Do you have any other instructions?

_____

_____

_____

I request that payment of authorized insurance benefits be made to Affiliates in Gastroenterolgy for services provided to me by the provider. I authorize the release to any referring physician or appropriate insurance company any medical information acquired in the course of my examination or treatment. I understand that I am financially responsible for any co-pay, deductible, co-insurance and non-covered expenses.

Signature_____

Notice of Privacy Practices

I acknowledge that the **Notice of Privacy Practices** from Affiliates in Gastroenterology was available to me.

Signature_____

AFFILIATES IN GASTROENTEROLOGY, P. A.

Medical History

Name_____Today's Date_____

Birthdate_____Referring Doctor_____

Current symptoms or problem: _____ Duration: _____

Medical Problems/Past Medical History (i.e. high blood pressure, diabetes, ulcers, cancer, hepatitis, colitis, etc)

_____ _____
_____ _____
_____ _____

Previous Surgeries (with dates):

_____ _____
_____ _____

Medications, Vitamins, Supplements (with strength and dosage):

_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies to medications? □ Yes □ No What Medicine?_____

If yes, describe reaction:_____

Do you use aspirin, Advil, Motrin, etc?_____ How often?_____

Do you take a blood thinner? If yes, which one?_____

Do you have a pacemaker?_____Defibrillator?_____

Have you ever had a colonoscopy? □ Yes □ No When?_____

Have you ever had an upper endoscopy? □ Yes □ No When?_____

Have you had your flu vaccine? □ Yes □ No When? _____

Have you had the Prevnar (Pneumococcal) vaccine? _____

When was your last pap smear? (Women) □ Yes □ No When? _____

When was your last mammogram? (Women) □ Yes □ No When? _____

Do you smoke? □ Yes □ No If yes, How many cigarettes per day?_____

Do you drink alcohol? □ Yes □ No If yes, how much per week?_____

Do you use Recreational Drugs? □ Yes □ No If yes, substance and how often?_____

_____

Have you had a blood transfusion? □ Yes □ No If yes, when?_____

Any family diseases? (i.e., cancer, heart, diabetes, colitis, liver) If so, whom?_____

_____

Please complete page 2

Do you now have or have you ever had:		When, Frequency, Duration, etc.
Problems Swallowing	☐ Yes ☐ No	
Painful Swallowing	☐ Yes ☐ No	
Heartburn	☐ Yes ☐ No	
Gas Pain	☐ Yes ☐ No	
Abdominal Pain	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Diarrhea	☐ Yes ☐ No	
Hemorrhoids	☐ Yes ☐ No	
Colitis	☐ Yes ☐ No	
Rectal Bleeding	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	
Dizziness	☐ Yes ☐ No	
Vertigo (room spinning)	☐ Yes ☐ No	
Visual Disturbances	☐ Yes ☐ No	
Eye Pain	☐ Yes ☐ No	
Hearing Difficulty	☐ Yes ☐ No	
Skin Problems	☐ Yes ☐ No	
Rash or Hives	☐ Yes ☐ No	
Swollen Glands	☐ Yes ☐ No	
Recurrent Sore Throat	☐ Yes ☐ No	
Thyroid Problems	☐ Yes ☐ No	
Post Nasal Drip	☐ Yes ☐ No	
Cough (chronic)	☐ Yes ☐ No	
Shortness of Breath	☐ Yes ☐ No	
Asthma/Wheezing	☐ Yes ☐ No	
Chest Pain	☐ Yes ☐ No	
Palpitations	☐ Yes ☐ No	
Difficulty or Pain Urinating	☐ Yes ☐ No	
Excessive Thirst	☐ Yes ☐ No	
Excessive Urination	☐ Yes ☐ No	
Weight Loss (recent)	☐ Yes ☐ No	
Weight Gain (recent)	☐ Yes ☐ No	
Abnormal Menses (women)	☐ Yes ☐ No	
Joint Pain	☐ Yes ☐ No	
Back Pain	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Easy Bruising/Bleeding	☐ Yes ☐ No	
Seasonal Allergies	☐ Yes ☐ No	
Food Sensitivity	☐ Yes ☐ No	

Print Patient's Name_____ Signature_____

I. OUR CONTACT INFORMATION

You may contact us with any concerns or for additional information regarding our privacy practices by calling or writing the Privacy Office at:

Affiliates in Gastroenterology, PA
Privacy Officer
101 Old Short Hills Rd, Suite 217 West Orange, NJ 07052
973-731-4600

Patient Acknowledgement that the Notice of Privacy Practices is available to me:

_____
Patient Printed Name

_____ **Date:**_____
Patient Signature