

# Welcome to Middlesex/Monmouth Gastroenterology

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

Reason for visit? \_\_\_\_\_

Referring/Primary Care Physician: \_\_\_\_\_

**Please List ALL Current Medications:**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies to Medications/Latex:** Yes  No  **Name, phone number and location of Pharmacy:**

_____	_____
_____	_____

**Medical history: Have you been or are you currently being treated for any of the following problems?**

(Some examples in each category are listed)

**Cardiac** (angina, MI, hypertension, arrhythmia, heart valve, etc) Yes  No

explain \_\_\_\_\_

**Dermatological problems** (skin disease) Yes  No

explain \_\_\_\_\_

**Endocrine problems** (diabetes, thyroid, cholesterol, etc) Yes  No

explain \_\_\_\_\_

**Respiratory** (asthma, emphysema, COPD, etc) Yes  No

explain \_\_\_\_\_

**Gastrointestinal** (polyps, diverticulosis, ulcer disease, GERD, IBS, IBD, liver disease etc) Yes  No

explain \_\_\_\_\_

**Cancer** (colon, stomach, breast, etc) Yes  No

explain \_\_\_\_\_

**Blood disorders** (clotting problems, anemia, leukemia, etc) Yes  No

explain \_\_\_\_\_

**Immunologic** (autoimmune, HIV, transplants, etc) Yes  No

explain \_\_\_\_\_

**Rheumatology** (Lupus, Arthritis, osteoporosis, etc) Yes  No

explain \_\_\_\_\_

**Neurological** (seizures, stroke, TIA, etc) Yes  No

explain \_\_\_\_\_

**Psychological** (Bipolar, depression, anxiety, etc) Yes  No

explain \_\_\_\_\_

**Other** \_\_\_\_\_

**Past Procedures:**

- Upper Endoscopy / year \_\_\_\_\_
- Sigmoidoscopy / year \_\_\_\_\_
- Colonoscopy / year \_\_\_\_\_

Past Surgeries:

- Gallbladder / year \_\_\_\_\_  Hysterectomy / year \_\_\_\_\_  Appendectomy / year \_\_\_\_\_  
 C-Section / year(s) \_\_\_\_\_

Other Surgeries (please list current to past)	Year	Reason/Diagnosis

**Family History (in relationship to you)**

Family Member	Alive (Age)	Deceased (Age)	Health status or cause of death	Family Member	Alive (Age)	Deceased (Age)	Health status or cause of death
Mother				Father			
Grandmother				Grandmother			
Grandfather				Grandfather			
Brother				Sister			
Brother				Sister			

Family history of Colitis or Crohn's Disease? Yes  No  (type/who) \_\_\_\_\_

Family history of Colon Cancer Yes  No  (who/age) \_\_\_\_\_

Family history of colonic Polyps? Yes  No  (who/age) \_\_\_\_\_

**Social History**

Do you drink alcohol now? Yes  No  Would you describe usage as: social mild moderate heavy

Employed: Yes  No  Retired  Occupation (current or last): \_\_\_\_\_

Have you ever used illegal drugs? Yes  No  type/when? \_\_\_\_\_

Marital Status: Single / Married / Divorced / Separated / Widowed

Do you have children: Yes  No  How Many? \_\_\_\_\_ Age range: \_\_\_\_\_

Do you smoke? Yes  No  How many packs per day? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Did you ever smoke? Yes  No  When did you stop? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Completed by: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
(Please sign)

**To be completed by the office:**

Information Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Physician's signature)

MIDDLESEX MONMOUTH GASTROENTEROLOGY

PATIENT CONTACT INFORMATION

Your medical records and information are CONFIDENTIAL. According to Federal HIPAA regulations, we are not allowed to discuss or release information to anyone but you the patient, unless authorized to do so by you.

Protecting your privacy is very important to us, but we also want to make sure that you receive information that is necessary.

To assist us in providing better service and care to you, please complete the information below.

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I give this office permission to contact me by:

\_\_\_\_\_ Telephone my home. Tel # is ( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_ Telephone my office. Tel # is ( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_

\_\_\_\_\_ Telephone my cell. Cell phone # is ( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_ Leave messages on answering machine/voice mail box.

\_\_\_\_\_ Other, please explain \_\_\_\_\_

If we have permission to discuss your information with anyone other than yourself, please write his/her name below and indicate your relationship to that person (i.e. spouse, child, friend, etc.)

Signature of Patient or Representative: \_\_\_\_\_

Print Name if Representative: \_\_\_\_\_

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

Today's Date: \_\_\_\_\_



# Middlesex Monmouth Gastroenterology

**PLEASE COMPLETE THE ENTIRE FORM & PRESENT WITH YOUR CURRENT INSURANCE CARDS**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M. Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Home #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell #: \_\_\_\_\_

Weekday phone # where you may be reached: \_\_\_\_\_ Email Address: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F  SS #: \_\_\_\_\_ Status: Single/ Mar/ Div/ Wid

Employer Name: \_\_\_\_\_ Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

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**PRIMARY INSURANCE INFORMATION:** Co-Pay Amount: \$ \_\_\_\_\_ ID #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's (Policy Holder) Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SS#: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

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**SECONDARY INSURANCE INFORMATION: (If applicable)** ID #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: (Policy holder) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SS#: \_\_\_\_\_ Subscriber's Birth date: \_\_\_\_\_

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Relative who does NOT live with you: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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**Your Primary Care Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

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

Physician who sent you to our office if different from above: \_\_\_\_\_

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**ASSIGNMENT OF BENEFITS:** I hereby authorize and instruct any and all insurance companies involved with my healthcare coverage, including Medicare, to make payment directly to Middlesex/Monmouth Gastroenterology. This is for the Professional Medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my insurance company or adjuster involved in the case, unless I have made alternate arrangements with respect to this data. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I also understand that any unpaid balances transferred to a collection agency or attorney are subject to an additional 25% Administrative Fee, and are my responsibility.

**MEDICARE PATIENTS PLEASE NOTE:** Medicare does not pay for routine well visits or screening office visits prior to a colonoscopy, unless you have a medical problem that warrants the visit.

**ALL PATIENTS HAVING A SCREENING COLONOSCOPY:** Check your insurance policy for preventative benefits. If you do not have these benefits, the colonoscopy, as well as the office visit and laboratory tests will not be paid for by your insurance, and the balance becomes your personal responsibility. Please call the phone number on the back of your insurance card and check your benefits.

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**I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW IT.**

Patient's Signature: \_\_\_\_\_

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