REFERRED BY:

Today's date ____/____/____ File no. _____

PATIENT INFORMATION

Name _____ ____Male ____Female ____Race Date of Birth ____/____/____

Address _____ ____Married ____ Separated ____ Divorced ____Widowed ____ Single

_____ _____ Zip Code Education ____years Elementary ____years High School

Telephone _____ Home number _____ Work number ____years College, Technical, Business, etc.

Social Security or Medicare No. _____ Occupation _____

INSURANCE: _____

SPECIAL PROBLEMS OR SYMPTOMS

1. In the blank lines below, please describe any special problems or symptoms you would like to discuss with the doctor today:

_____

_____

_____

_____

2. How long have you had this problem? . . . . . ____for 1 week ____for 1 month ____for 1 year ____over 1 year
3. Have you ever seen a doctor for this problem in the past? . . . . . ____Yes ____No

   If YES: a. How did the doctor diagnose your problem? _____

   _____

   b. How did the doctor treat your problem? _____

   _____

   c. Did the treatment help you? . . . . . ____Yes ____No

GENERAL SCREEN

1. Please place an (X) next to any of the following problems that you have right now:

_____frequent headaches	_____high blood pressure	_____trouble with liver
_____trouble with eyes or vision	_____trouble with stomach or digestion	_____trouble with thyroid
_____trouble with ears or hearing	_____vomiting	_____trouble with bruises
_____trouble with nose	_____trouble with bowels	_____aching muscles or joints
_____congested nose or nose bleeds	_____constipation	_____osteoporosis
_____trouble smelling	_____loose bowels	_____numbness in fingers
_____coughing spells	_____blood in stools	_____crying spells
_____coughing up a lot of phlegm	_____trouble with urination	_____work or family problems
_____trouble breathing (shortness of breath)	_____difficulty starting urine	_____sexual difficulties
_____dizzy spells	_____trouble with genitals	_____fever
_____heart trouble	_____trouble with periods	_____weight changes
		_____fatigue

2. Have you ever considered committing suicide? . . . . . ____Yes ____No
3. Have you ever used marijuana or heroin, LSD, or similar drugs? . . . . . ____Yes ____No
4. Are you allergic to any medications, foods or other substances? . . . . . ____Yes ____No

   If YES, what? _____
5. List all medications you are currently taking: _____

   _____
6. When is the last time you had a physical examination? . . . . . _____Year
7. Have you ever been told you had any chronic or serious illness? . . . . . ____Yes ____No

   If YES, please list the illnesses you have now or have had: _____

   _____
8. Give the following information for the last three times you have been hospitalized starting with the most recent. (Do not list normal pregnancies.)

	HOSPITALIZATION (1)	HOSPITALIZATION (2)	HOSPITALIZATION (3)
Type of operation or illness:			
Month and year hospitalized:			
Name of hospital:			
City and State:			

9. Please list the following information for your blood relatives:

	Year of Birth	*Major Illnesses*		If dead, age at death and cause. *Age*	*Cause*
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers or Sisters	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Your Signature: _____

AMOUNT PER DAY:
Coffee or Tea: _____
Cigarettes: _____
Alcohol: _____
Spices: _____
Aspirin: _____

When was your last:

Flu Vaccine _____
Pneumonia Vaccine _____

FEMALE PATIENTS ONLY

Any Chance of being Pregnant? _____

Date of last menstrual period

_____

PHARMACY INFORMATION

PHARMACY NAME:_____

PHARMACY ADDRESS:_____ **CITY**_____

PHARMACY PHONE#_____

PATIENT INFORMATION

NAME:_____

DATE OF BIRTH:_____

TODAY'S DATE:

	LIST OF MEDICATION
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
19	
20	

PATIENT INFORMATION FORM

Which Office are you being seen at today: ☐ North Bergen ☐ Jersey City

Which Doctor are you seeing today? ☐ Dr. Port ☐ Dr. Raskin ☐ Dr. Tepler

REFERRING PHYSICIAN: _____ Phone #_____

PATIENT INFORMATION:

Full Name: _____ Sex_____

Address: _____

City: _____

State/Zip: _____

Phone #:_____ Cell #_____

Email: _____

Date of Birth: _____ Marital Status: _____

Driver's License #: _____

SS#: _____

Race: __Hispanic __American Indian __White __Hawaiian __Black __Asian __Other

SPOUSE :

Full Name: _____

Employer: _____

Employer Phone #:_____

SS#: _____ DOB:_____

Cell #: _____

Whom may we contact in case of emergency?

_____

Phone #: _____

Nearest Relative not living with you?_____

Phone #:_____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____

Employer Phone #: _____

Employer Address: _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION:

Insurance Co. Name: _____

Phone #: _____

Co Pay $ _____

Insured's Name: _____ DOB_____

Policy #: _____ Group #: _____

Relationship to Insured _____

Address Where Claims are To Be Mailed: _____

_____

_____

SECONDARY INSURANCE INFORMATION:

Insurance Co. Name:_____

Phone #: _____

Co-Pay $ _____

Insured's Name:_____ DOB:_____

Policy #:_____ Group#:_____

Relationship to Insured _____

Address where claims are to be mailed:_____

_____

_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

PATIENT: (Signature)_____ Date _____

NOTICE OF PRIVACY PRACTICES
GASTROENTEROLOGY MEDICAL ASSOCIATES
9223-43 KENNEDY BOULEVARD
NORTH BERGEN, NJ 07047
(201) 868-2849

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name_____ Signature_____ Date_____