TEANECK GASTROENTEROLOGY ASSOCIATES, PA

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Thank you for choosing the office of TEANECK GASTROENTEROLOGY ASSOCIATES, PA. You will receive an automated phone call to confirm your appointment 3 days in advance of your appointment date. Please make every effort to **Confirm and keep your scheduled appointment.**

PATIENT NAME:_____

APPOINTMENT DATE: _____ **TIME:**_____

- **Complete the enclosed forms and BRING THEM on the day of your visit. If you are unable to complete them on your own, please have a family member assist you or come to your appointment 30 minutes early so we can assist you.**
- **Bring a complete list of your CURRENT MEDICATIONS.**
- **Bring any RECENT LAB RESULTS, CT SCANs, MRIs or ULTRASOUNDS of the Abdomen, or any testing that is related to the reason why you are seeing the doctor.**
- **Bring your INSURANCE CARDS, PHOTO IDENTIFICATION and ANY NECESSARY REFERRAL from your primary care physician.**

PAYMENT is expected as services are rendered. Please be prepared to pay your copay at the time of your visit. We gladly accept cash, checks, American Express, Discover, Visa and MasterCard.

FACE COVERINGS ARE REQUIRED IN THE OFFICE. PLEASE COME ALONE SO WE MAY PROPERLY SOCIALLY DISTANCE IN THE WAITING AREA.

DIRECTIONS FOR GPS, PLEASE USE THE FOLLOWING ADDRESS:
1092 KATHERINE STREET, TEANECK, NJ

PATIENT REGISTRATION FORM

FULL NAME: _____ **Date of Birth:** _____ **GENDER AT BIRTH**: ___male ___female

Address:_____
STREET CITY STATE ZIP

Cell Phone: _____ Home Phone : _____ Work Phone: _____

GENDER IDENTITY: ____male ____female **MARITAL STATUS**: ___single ____married ____divorced ____widowed ____legally separated

ETHNICITY: ____Hispanic ____Not Hispanic **RACE**: ___American Indian ___ Alaskan ___ Asian ___ Black ___ Mixed Race ___ Pacific Islander ___White

PRIMARY LANGUAGE: _____

YOUR EMPLOYER: _____**Occupation:**_____

Your Employer Address: _____**Phone:** _____

NOTIFY IN CASE OF EMERGENCY: _____ **PHONE NUMBER**:_____**RELATIONSHIP:**_____

The **PATIENT PORTAL** gives our patients secure, up to the minute access to their medical records, diet and educational forms, appointment, refill, billing history and statements. **PLEASE NOTE: PATIENT PORTAL ACCESS REQUIRES AN E-MAIL ADDRESS.**

Would you like to receive Paperless Billing Statements through the Patient Portal? _____ yes _____ no

E-MAIL Address:_____Each patient must have their own unique email address.

Primary Care Physician: _____**Referring Physician**:_____

Address:_____Address:_____

Phone: _____ Phone: _____

OUR PRACTICE SENDS PRESCRIPTIONS ELECTRONICALLY. THIS REQUIRES YOUR PHARMACY INFORMATION.

Local Pharmacy Name:_____City:_____ Phone:_____

Mail Order Pharmacy:_____

PLEASE PROVIDE YOUR INSURANCE CARDS FOR SCANNING AT EACH VISIT.

INSURANCE:_____ **ID:**_____

SUBSCRIBER:_____ **DOB:**_____

INSURANCE:_____ **ID:**_____

SUBSCRIBER:_____ **DOB:**_____

I understand that I am responsible for my bill. I understand that if my insurance requires a referral, I will provide it at the time of my visit or reschedule until such time as I can provide the necessary referral. I authorize Drs. Schmidt, Micale, Palance, Lin, Welinsky and/or their employees to:

- **Release any information to my insurance companies necessary for processing my insurance claim. A copy of this authorization can be used in place of the original.**
- **Receive direct payment from my insurance companies**
- **Release to and receive from any laboratories, hospitals, doctors or other healthcare providers, any information regarding my medical condition(s) and medical history necessary to treat me and coordinate my healthcare.**
- **Leave results of the tests performed on me, which are considered within normal limits for my health status, on my home telephone recording device, cell phone, e-mail or given to a spouse or family member.**
- **Call me at work to remind me of my appointment or to request a return call. This request can also be left with a spouse, family member or on a home telephone recording device, cell phone or e-mail.**
- **Download my pharmacy benefits and my e-prescribe history**
- **Communicate with me through the Patient Portal**
- **Send my statement via the Patient Portal (only when providing an e-mail address)**
- **Use Jot Form to obtain demographic and health history information**

Patient Signature:_____ **Date:**_____

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PRINT Patient Name:_____ **Date of Birth:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA) , I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Notification of any breaches in unsecured Protected Health Information

I have received and read and understand your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact his organization to obtain a copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, they you are bound to abide by such restrictions.

Signature: X_____ **Date:**_____

I will allow Drs Schmidt, Micale, Palance, Lin & Welinsky or their designees to discuss my protected health information with the following person(s) listed below:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below:

Date:_____ Initials:_____

Reason:_____
_____

HEALTH HISTORY

NAME:_____DOB:_____Today's Date:_____

CHIEF COMPLAINT: (What brings you here today?): _____

PAST MEDICAL HISTORY: **Please indicate any significant medical conditions:** ___No Significant Past History

___ Anemia	___ Diabetes	___ HIV/AIDS	___ Stroke	___ Colon Polyps
___ Asthma	___ Heart Disease	___ Joint Replacement	___ Ulcers	
___ Cancer	___ Hernia	___ Kidney Disease	Other:_____	
___ Cirrhosis	___ High Blood Pressure	___ Pneumonia	_____	

RECENT TRAVEL OUTSIDE THE COUNTRY ? _____YES _____NO Where?_____

PAST SURGICAL HISTORY: List any surgeries you have had, where they were performed and the approximate year. Please be sure to specifically include any surgeries of the abdomen, chest, head and neck. If none, please indicate **NONE**.

Surgery:_____ Doctor/Facility:_____ When:_____

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Surgery:_____ Doctor/Facility:_____ When:_____

Surgery:_____ Doctor/Facility:_____ When:_____

HAVE YOU EVER HAD A COLONOSCOPY BEFORE? __YES __NO Where_____ When_____

HAVE YOU EVER HAD AN UPPER ENDOSCOPY BEFORE? __YES __NO Where_____ When _____

MEDICATIONS: Please List **ALL** Medications you take, both Prescription and Over the Counter**. If you take NO MEDICATIONS, please indicate NONE.**

_____ _____

_____ _____

DID YOU RECEIVE THE COVID VACCINE? ___ Y ___ N Choose: ___ Pfizer ___ Moderna __ J & J When:_____

ALLERGIES – Please list any and all allergies in the appropriate category, or indicate NONE

DRUG ALLERGIES:

FOOD ALLERGIES:_____ ENVIRONMENTAL ALLERGIES:_____

HAVE AN ALLERGY TO: IV CONTAST? _____ Y _____ N IODINE?_____ Y _____ N

PROBLEMS WITH ANESTHESIA IN THE PAST? _____ Y _____ N

SOCIAL HISTORY: Please indicate which of the following substances you use and the frequency of use:

Tobacco? ___ Never ___ Previously but quit ___ YES ____ # Packs per day ____# of years smoking

Vape? ___ Never ___ Previously but quit ___YES ____# of year vaping

Alcohol? ___ Never ___ Rarely ___Socially ___ Moderately ___ Daily ____# of drinks per day

Drugs? ___ Never ___Previously but quit IV Drugs? _____ Yes _____ No

Caffeine? ___ Never ___ Rarely ___Socially ___ Moderately ___ Daily _____ # of drinks per day

Name:_____ DOB:_____

FAMILY HISTORY: Please tell us about your family history. Be sure to include cancers of all kinds as well as those of the GI tract and liver.

MOTHER: _____ ____ LIVING _____ DECEASED

FATHER: _____ ____ LIVING _____ DECEASED

SISTER: _____ ____ LIVING _____ DECEASED

BROTHER: _____ _____ LIVING _____ DECEASED

REVIEW OF SYSTEMS – PLEASE CHECK ALL THAT APPLY

____Weight Gain

____Weight Loss

____Swelling

____Short of Breath

____Chest pain

____Sleep Apnea

____Emphysema

____Wheezing

____Chronic cough

____Rectal bleeding

____Painful bowel Movements?

____Nausea

____Vomiting

____Change in

Bowel Movements

____Abdominal pain

____Constipation

____Loss of appetite

____Diarrhea

____Hemorrhoids

____Hepatitis

____Anorexia

____Gas/Bloating

____Heartburn

____Jaundice

____Difficulty Swallowing

____Blood Clots

____Bruising

____Transfusions

____Blood Thinners?

_____

Name of Blood Thinner (if any)

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian: X_____ Date:_____