Patient Registration

Name: _____ Date: _____ Sex: _____

Address: _____ Date of Birth: _____ Age: _____

_____ SS#: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single Cell Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

GOVERNMENT MANDATED QUESTIONS ***Please answer ALL 3 questions***

Ethnicity (Circle 1): Hispanic / Non-Hispanic **Preferred Language:** _____

Race (Circle 1): American Indian/Alaska Native Asian Black /African American

Native Hawaiian/Other Pacific Islander White/Caucasian Other Unknown

Pharmacy name, telephone & address: _____

_____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Patient's Employer/School: _____ Phone Number: _____

Employer/School Address: _____

Referring Provider: _____ Address: _____ Phone: _____

Primary Provider: _____ Address: _____ Phone: _____

Primary Insurance

Name: _____

Policy Holder: _____

Relationship to Insured: _____

Birth Date of Insured: _____

Policy # _____ Group # _____

Secondary Insurance

Name: _____

Policy Holder: _____

Relationship to Insured: _____

Birth Date of Insured: _____

Policy # _____ Group # _____

Social History

Tobacco: ☐ unknown if ever smoked ☐ never smoker ☐ former smoker ☐ current some day smoker
☐ current every day smoker ☐ smoker, current status unknown

current/former smoker for how long: _____ current/former smoker packs/per day: _____

Alcohol: ☐ no alcohol use ☐ past alcohol use ☐ recovering alcoholic ☐ occasional/social alcohol use ☐ current alcohol use

How many drinks per week currently or in past: _____

Islandwide Gastroenterology
1205 Franklin Avenue
Suite 150
Garden City, NY 11530
Phone 516.222.0067

Islandwide
Gastroenterology, P.C.
Dr. Philip R. Cassar
Dr. Robert J. Bonasera
1205 Franklin Avenue
Suite 150
Garden City, NY 11530

Name_____

Date_____

Reason you want to see the doctor today

_____

_____

_____

Who Referred You

_____

Have you experienced any of the below conditions (Circle all that apply)

Seizure	Lupus	Excessive Belching
Stroke	Diabetes	Getting full easy when you eat
Thyroid Disease	GERD/Heartburn	Lactose Intolerance
Asthma	Trouble Swallowing	Blood in stool
Emphysema	Barrett's Esophagus	Colon Cancer
Pneumonia	Bloating	Colon Polyps
Sleep Apnea	Pass a lot of gas	Hemorrhoids
Shortness of Breath	Nausea or Vomiting	Anemia
High Blood Pressure	Loss of Appetite	Pancreatitis
Chest Pain	Unwanted weight loss	Gallstones
Heart Disease	Ulcer	Hepatitis A, B, C
Heart Attack	Gastritis	Fatty Liver
Irregular Heart Beat	H. Pylori	Crohn's Disease
Heart Murmur	Abdominal pain	Ulcerative Colitis
High Cholesterol	Irritable bowel syndrome	Diverticulosis or Diverticulitis
Congestive Heart Failure	Constipation	Kidney not working well
Anxiety or Depression	Diarrhea	Kidney Stones
Other	Other	Gout

- List the surgeries you have had

_____

_____

_____

_____

- Had a Colonoscopy or Endoscopy in past

_____

- Please List your current medications (include over the counter medications)

Med	Dosage	Frequency

- Please List Any Drug Allergies (including Iodine, Eggs, Sulfur, Radiology Contrast)

_____

_____

_____

- Please list the ages of your parents, brothers, sisters **AND** record any medical problems they may have

_____

_____

_____

_____

_____

- Anyone in the family with cancer of the Esophagus, Stomach, Pancreas, Gallbladder, Liver or Colon. Anyone in the family with Colon Polyps, Barrett's or Cirrhosis

_____

_____

_____

_____

_____

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I understand that at times I may be notified of test results by phone (Check all that apply).

_____I allow my doctor's office to leave messages on my home phone and cell phone

_____I allow my doctor's office to leave a message with the specified family members

_____

_____ _____

Patient Signature Date

Authorization to Release Information

I hereby authorize Provider Islandwide Gastroenterology PC to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

Islandwide Gastroenterology, P.C.

1205 Franklin Avenue, Suite 150
Garden City, NY 11530

Name _____

Mark Yes/No as appropriate

Yes No **Constitutional**
- ☐ ☐ Fatigue
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss
- ☐ ☐ Fever
- ☐ ☐ Chills
- ☐ ☐ Night sweats

Yes No **Endocrine**
- ☐ ☐ Excessive thirst
- ☐ ☐ Heat/Cold intolerance

Yes No **Eyes/Ears**
- ☐ ☐ Dry eyes
- ☐ ☐ Blurry vision
- ☐ ☐ Eye redness
- ☐ ☐ Eye itching
- ☐ ☐ Eye pain
- ☐ ☐ Ear pain
- ☐ ☐ Ringing
- ☐ ☐ Hearing loss

Yes No **Nose/Throat**
- ☐ ☐ Nasal congestion
- ☐ ☐ Nasal discharge
- ☐ ☐ Post-nasal drip
- ☐ ☐ Nose bleeds
- ☐ ☐ Mouth ulcers
- ☐ ☐ Bleeding gums
- ☐ ☐ Sore throat
- ☐ ☐ Hoarseness

Yes No **Respiratory**
- ☐ ☐ Shortness of Breath
- ☐ ☐ Painful breathing
- ☐ ☐ Cough
- ☐ ☐ Coughing blood
- ☐ ☐ Phlegm/mucous
- ☐ ☐ Wheezing

Yes No **Cardiovascular**
- ☐ ☐ Chest pain
- ☐ ☐ Palpitations
- ☐ ☐ Difficulty breathing lying flat
- ☐ ☐ Difficulty breathing at night
- ☐ ☐ Leg swelling

Yes No **Gastrointestinal**
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Painful swallowing
- ☐ ☐ Indigestion
- ☐ ☐ Bloating
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Blood in stool
- ☐ ☐ Hemorrhoids
- ☐ ☐ Incontinence of stool

Yes No **Urinary**
- ☐ ☐ Frequent urination
- ☐ ☐ Painful urination
- ☐ ☐ Nighttime urination
- ☐ ☐ Blood in urine
- ☐ ☐ Incontinence of urine

Yes No **Menstrual (Women)**
- ☐ ☐ Vaginal discharge
- ☐ ☐ Abnormal vaginal bleeding
- ☐ ☐ Irregular menses
- ☐ ☐ Pelvic pain

Yes No **Breast (Women)**
- ☐ ☐ Nipple discharge
- ☐ ☐ Breast tenderness
- ☐ ☐ Breast lump

Yes No **Musculoskeletal**
- ☐ ☐ Neck/Back pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint stiffness
- ☐ ☐ Joint swelling
- ☐ ☐ Muscle pain

Yes No **Skin**
- ☐ ☐ Rash
- ☐ ☐ Dry skin
- ☐ ☐ Itching
- ☐ ☐ Hair loss
- ☐ ☐ Nail problems

Yes No **Neurologic**
- ☐ ☐ Headache
- ☐ ☐ Dizziness
- ☐ ☐ Vertigo
- ☐ ☐ Loss of consciousness
- ☐ ☐ Numbness
- ☐ ☐ Weakness
- ☐ ☐ Tremor

Yes No **Psychiatric**
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Insomnia
- ☐ ☐ Confusion
- ☐ ☐ Poor concentration
- ☐ ☐ Memory loss

Yes No **Hematologic**
- ☐ ☐ Anemia
- ☐ ☐ Easy bruising
- ☐ ☐ Enlarged lymph nodes

Internal Use Only
Reviewed by _____
Date _____