GastroCare LI

Gastroenterology

Bradley S. Rieders, M.D., F.A.C.G.
Gautam M. Reddy, M.D.

Liver Diseases
Nutrition

Please make sure you have the following items with you for your visit

- **Insurance card**
- **Photo ID**
- **A referral from your primary doctor (if required by your insurance)**
- **Medication list with dosing**
- **Completed patient registration forms**
- **Any medical records you may have that are relevant to your visit (bloodwork, sonogram, CT scan, etc)**

210 E. Sunrise Highway, Valley Stream, NY 11581 • 516-825-8484 • Fax 516-825-8491
78-01 Myrtle Avenue, Glendale, NY 11385 • 718-657-2789
www.GastroCareLI.com

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PATIENT QUESTIONNAIRE

DATE _____ DATE OF BIRTH _____ AGE _____ SEX _____

NAME _____

ADDRESS _____ **EMAIL:** _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK _____ CELL _____

SOCIAL SECURITY # _____ MEDICARE # _____

PRIMARY INSURANCE _____ POLICY # _____

NAME OF INSURED _____

SECONDARY INSURANCE _____

HOW DID YOU HEAR ABOUT US ? _____

PRIMARY CARE PHYSICIAN _____

MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

Please provide us with a telephone number of a relative or friend in case of any emergency

NAME OF RELATIVE OR FRIEND _____ PHONE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GASTROCARE LI RESERVES THE RIGHT TO MODIFY THE PRIVACY PRACTICES OUTLINED IN THE NOTICE.

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY _____

NAME OF PATIENT _____

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PATIENT REPRESENTATIVE _____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT _____

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PERMISSION FOR DISCLOSURE OF HEALTH INFORMATION

VERIFICATION OF FAMILY/FRIEND

DATE _____

PATIENT'S NAME _____ SS # _____

DOB _____

I, _____ GIVE PERMISSION TO GASTROCARE
(PRINT NAME)

TO DISCUSS MY PRIVATE HEALTH INFORMATION WITH:

NAME _____ RELATIONSHIP TO PATIENT _____
(PRINT)

NAME _____ RELATIONSHIP TO PATIENT _____
(PRINT)

NAME _____ RELATIONSHIP TO PATIENT _____
(PRINT)

NAME _____ RELATIONSHIP TO PATIENT _____
(PRINT)

NAME _____ RELATIONSHIP TO PATIENT _____
(PRINT)

SIGNATURE OF PATIENT _____

You have the right to change this disclosure of medical history at any time, as long as you notify this office in writing.

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AUTHORIZATION FOR USE OF SIGNATURE ON FILE

ASSIGNMENT OF BENEFITS

The undersigned hereby assigns all monetary benefits to be received by me from any individual, insurance company, or other person or organization as a result of any medical treatment or related services rendered to me by GastroCare LI, partial or full payment directly to GastroCare LI of such benefits.

I also authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to GastroCare LI physicians or suppliers for all services rendered to me using "SIGNATURE ON FILE".
I request that payment of authorized Medicare benefits be made either to me or on my behalf to GastroCare LI for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This agreement is applicable to all services rendered by GastroCare LI at any future date so long as I do not cancel this agreement in writing.

Due to the ever-changing coverage of insurance plans, in order to accommodate all our patients, we will continue to participate with many managed care plans. However, you are responsible for knowing the benefits and exclusions of your plan. It will be your responsibility to provide us with complete and accurate insurance information. As always, we will file the claim, but any procedures not covered by your plan will be your responsibility.

Thank you in advance for your anticipated cooperation in this matter.

Date_____

Patient (print name)_____

Patient's Signature_____

Patient's Social Security Number_____

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GastroCare LI- Medical History Form

Name_____**Date of Birth**___/___/___ **Today's date:**___/___/__

Race (please circle): White Hispanic Black/African American Asian

Native Hawaiian American Indian/Alaska Native Other Pacific Islander

Decline to report Other:_____

Language: English Spanish Italian Hindi Russian Other:_____

Reason for your visit today:

Abdominal Pain	Heartburn	Ulcers	Indigestion	Crohn's Disease
Change in bowel habits	Constipation	Diarrhea	Weight loss/ gain	Ulcerative colitis
Decreased appetite	Nausea	Vomiting	Difficulty swallowing	H-Pylori
Rectal Bleed	Blood in Stool	Hemorrhoids	Anemia	Gall Bladder disease
Jaundice	Pancreatitis	Hepatitis A B C		Other:
Appendicitis	Hernia	Gall Bladder Disease		

Please list all **medication** (prescriptions, OTC, Herbs, etc) you are presently taking:
****Please include Aspirin, Advil or any blood thinner type of medication****

Name	Dosage	Reason for taking

Local pharmacy name:_____ **Phone #**_____

Address:_____ **City/ Town:**_____ **State**_____
Does GastroCare LI have permission to access your **electronic Rx history?** YES OR NO

Please list any **allergies** you have to medication, x-ray dyes, or other substances and reaction type:

_____

_____

_____

Patient Name:_____ **Date of birth:**___/___/___

Past Medical History

Please circle if you have had problems in the past or are presently diagnosed with any the following:

High Blood Pressure	Diabetes Type I or II	Hay Fever	Headaches
Heart Disease	Thyroid Disease	Rheumatic Fever	Anxiety
Chest Pain	Kidney Disease	Skin Disease	Depression
Shortness of Breath	Kidney Stones	Blood Disorders	Alcohol Abuse
Cancer	Gout	Bronchitis	Drug Abuse
Palpitations	Urinary Disorders	Pneumonia	Venereal Disease
Asthma	Swollen Ankles	Persistent Cough	Hepatitis A B C
Lightheadedness	Arthritis	Crohn's Disease	T.B.
COPD	Low back Problems	Celiac Disease	Other:

Please list and supply dates of any **surgeries:** _____

_____

Family History:

Gastrointestinal Disorders (polyps, cancer, etc) _____

_____

All other cancers:_____

Other (diabetes, heart disease, etc) _____

Social History:

Tobacco use: NO YES ___**# per week** Alcohol: NO YES_____**# per week**

Recreational Drugs: NO Yes **Type:** _____**How often:**_____

Eating Habits: Healthy Fairly Healthy Mostly Junk Food

****If you are interested in meeting with our Nutritionist on staff please notify the receptionist****

9/11 exposure? YES NO

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24 HOURS CANCELLATION & "NO SHOW" FEE POLICY

EACH TIME A PATIENT MISSES AN APPOINTMENT WITHOUT PROVIDING PROPER NOTICE ANOTHER PATIENT IS PREVENTED FROM RECEIVING CARE.
THEREFORE, GASTROCARE LI RESERVES THE RIGHT TO CHARGE A FEE OF $50.00 FOR AN OFFICE VISIT AND $100.00 FOR A SCHEDULED PROCEDURE THAT IS MISSED (NO SHOW) OR NOT CANCELLED WITHIN 24 HOURS.

"NO SHOW" FEES WILL BE BILLED TO THE PATIENT. THIS FEE IS NOT COVERED BY INSURANCE AND MUST BE PAID PRIOR TO YOUR NEXT APPOINTMENT.

THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION AS WE STRIVE TO PROVIDE THE BEST CARE TO ALL OF OUR PATIENTS.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED THIS NOTICE AND UNDERSTAND THIS POLICY.

_____

PRINTED NAME

_____

SIGNATURE

_____

DATE

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