



North Shore Gastroenterology Associates, P.C.
233 E. Shore Rd., Suite 101
Great Neck, NY 11023
Phone: 516-487-2444
Fax: 516-487-2446
www.northshoregastro.com

YOU ARE SCHEDULED FOR AN APPOINTMENT AT OUR GLEN COVE OFFICE. LOCATED AT:

**10 MEDICAL PLAZA
SUITE 303
GLEN COVE, NY 11542
(516) 676-0239**

YOU MUST COMPLETE THE FOLLOWING FORM IN ITS ENTIRETY PRIOR TO YOUR APPOINTMENT. WE ASK THAT YOU RETURN THE COMPLETED FORM TO US IN ONE OF THE FOLLOWING WAYS:

- 1. VIA OUR SECURE E-MAIL: NSGA1@PROTONMAIL.COM**
- 2. FAX: 516-487-2446**
- 3. ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT WITH THE COMPLETED PAPERWORK**

FAILURE TO COMPLETE YOUR PAPERWORK PRIOR TO YOUR APPOINTMENT MAY RESULT IN YOUR APPOINTMENT BEING DELAYED!

IF YOU HAVE HAD ANY LABS OR BLOOD WORK DONE WITHIN THE PAST YEAR PLEASE FAX OR E-MAIL THEM TO OUR OFFICE, AT THE E-MAIL ADDRESS OR FAX NUMBER PROVIDED ABOVE. YOU MAY ALSO BRING COPIES WITH YOU AND GIVE THEM TO OUR FRONT DESK STAFF WHEN YOU CHECK-IN.

THANK YOU!



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Today's Date: _____ Doctor you are seeing today: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Date of Birth: _____ Age: _____

Cell Phone: (____) _____ Male Female SS #: _____

Work Phone: (____) _____ Employer: _____ Occupation: _____

Email Address: _____ Marital Status: _____

Emergency Contact Name: _____

Phone: _____ Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Who can we thank for referring you to our practice? _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

SS #: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

SS #: _____ Relationship to Patient: _____

I hereby authorize the Doctors of North Shore Gastroenterology Associates, P.C. to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my department for purposes of review, investigation, or evaluation of claims. I authorize payment of medical benefits to North Shore Gastroenterology Associates, P.C., and acknowledge that I am financially responsible for any unpaid balance. I have been provided access to North Shore Gastroenterology Associates, P.C. HIPAA policies.

Patient or Authorized Signature: _____ Date: _____

PATIENT HISTORY FORM

Name _____ Date: _____

Reason For Today's Visit: _____

PAST MEDICAL HISTORY:

Yes	No Hypertension	Yes	No Lyme Disease	Yes	No Rheumatic Fever
Yes	No Diabetes	Yes	No Venereal Disease	Yes	No Thyroid Disease
Yes	No Pneumonia	Yes	No Mononucleosis	Yes	No Gout
Yes	No Asthma	Yes	No Arthritis	Yes	No Depression
Yes	No Emphysema	Yes	No Stroke		
Yes	No Cancer: Site: _____			Date Diagnosed: _____	
Yes	No Heart Attack: Date: _____				
Angina: Last Episode: _____					
Other: Specify: _____					

PAST SURGICAL HISTORY (Check ALL that apply):

Tonsils / Date: _____	Cesarean Section / Date: _____
Appendix / Date: _____	Hysterectomy / Date: _____
Hernia / Location: _____ / Date: _____	Abdominal Aortic Aneurysm Repair / Date: _____
Gallbladder open laparoscopic / Date: _____	
Other (please include dates): _____	

MEDICATIONS (Include prescriptions, over-the-counter medications, vitamins/supplements, minerals, herbs. If additional space is needed, please attach a separate sheet):

Name	Dose (mg, g)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies? If so, please list them: _____
 Do you take Aspirin/Anti-Inflammatory Meds? (NSAIDS, e.g., Motrin, Advil) Specify: _____

SOCIAL HISTORY (Check ALL that apply):

Smoke Cigarettes	Frequency: _____
	If you previously smoked, when did you quit? _____
Drink Alcohol	Frequency: _____
Drink Coffee or Tea	Frequency: _____
Recently Traveled Outside of the U.S.	Where/When: _____
Received a Blood Transfusion	No. of Units/When: _____
Routine Blood Work Drawn (within 1 year)	Location/Phone #: _____

PATIENT HISTORY FORM (Continued)

Name _____ Date: _____

FAMILY HISTORY (Check ALL that apply): Note: Not your own history. Include 1st, 2nd and 3rd degree relatives. This includes parents, children, siblings, nieces/nephews, aunts, uncles, cousins, grandparents, grandchildren, and great grandparents.

Colon Cancer	Relationship: _____	Age Diagnosed: _____
Colon Polyps	Relationship: _____	Age Diagnosed: _____
Endometrial/Uterine Cancer	Relationship: _____	Age Diagnosed: _____
Stomach or Gastric Cancer	Relationship: _____	Age Diagnosed: _____
Ulcerative Colitis or Crohn's Disease	Relationship: _____	Age Diagnosed: _____
Breast Cancer or Ovarian Cancer	Relationship: _____	Age Diagnosed: _____
Other : _____	Relationship: _____	Age Diagnosed: _____

REVIEW OF SYSTEMS:

Skin:

Yes No Rash
Yes No Itching
Yes No Jaundice

Neurologic:

Yes No Headache
Yes No Focal Weakness
Yes No Numbness
Yes No Fainting

Eyes:

Yes No Visual loss
Yes No Double vision
Yes No Pain

Ears/Nose/Throat:

Yes No Hearing loss
Yes No Ringing in ears
Yes No Dizziness
Yes No Runny nose
Yes No Nosebleed
Yes No Sore throat
Yes No Hoarseness

Respiratory:

Yes No Shortness of breath
Yes No Cough
Yes No Wheezing
Yes No Coughing up blood
Yes No Pain with breathing

Cardiovascular:

Yes No Palpitations
Yes No Chest pain/tightness with exertion
Yes No Shortness of breath with exertion
Yes No Awakening at night short of breath
Yes No Swelling of ankles or lower legs
Yes No Aching muscles or joints
Yes No Back pain

Gastrointestinal:

Yes No Frequent or severe heartburn
Yes No Excessive belching
Yes No Food getting stuck when swallowing
Yes No Abdominal pain
Yes No Nausea
Yes No Vomiting
Yes No Vomiting blood
Yes No Constipation
Yes No Change in caliber of stool
Yes No Diarrhea
Yes No Black colored stool (like tar)
Yes No Excessive flatulence
Yes No Had Endoscopy: When: _____
Yes No Had Colonoscopy: When: _____
Yes No Had Sigmoidoscopy: When: _____
Yes No Had a GI Series: When: _____
Yes No Prior Ultrasound: When: _____
Yes No Prior CT Scan When: _____

Urinary:

Yes No Frequent urination
Yes No Pain or burning with urination
Yes No Constant feeling of an urge to urinate
Yes No Dark or Bloody Urine

Men:

Yes No Weak or slow urinary stream
Yes No Prostate problems
Yes No Swelling or lumps in testicles
Yes No Burning or discharge from penis

Women:

Yes No No longer get periods
Yes No Irregular menstrual periods
Yes No Heavy menstrual periods

Rheumatologic:

Yes No Swollen joints



PATIENT AUTHORIZATION FOR DISCLOSURE

I acknowledge the Privacy Policies of this practice and I authorize the Use and Disclosure of Protected Health Information as follows:

Information to Be Used or Disclosed:

The information covered by this authorization includes:

My entire patient chart and billing information

Only the following: _____

Persons Authorized to Use or Disclose Information:

Information listed above may be used or disclosed by: North Shore Gastroenterology Associates, P.C.

Persons to Whom Information May Be Disclosed:

Information described above may be disclosed to other medical practices, my insurance company and:

Name of Person(s)/Organization(s): _____

Expiration Date of Authorization:

This authorization is effective through _____ unless revoked or terminated by the patient or patient’s personal representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to North Shore Gastroenterology Associates, P.C., and contacting the Office Manager.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Regulations.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship

COLLECTION FEE/ATTORNEYS’ FEE ACKNOWLEDGMENT

I, _____ understand that if my account balance becomes overdue and the account is referred to a Collection Agency, a collection fee of 35% will be added to the overdue amount and that I am financially responsible for this fee. I also understand that I am responsible for any reasonable attorneys’ fees incurred to collect the past due balance.

Patient’s Signature

Date



In order to provide you with the best care possible, North Shore Gastro **REQUIRES ALL PATIENTS** to sign up for a **SECURE** FollowMyHealth (FMH) Patient Portal Account. Please fill out the form below, and we will create the account for you. Your information will be used **ONLY** for setting up your account! Once your account is created your unique username and temporary password will be emailed to you at the email address provided on this form.

Once your account is setup, you will be able to:

- Access your medical records for **FREE** (if you request them from the office, you will be charged .75 cents per page)
- Send secure messages to your Doctor
- View lab, test and procedure reports as soon as they are available
- Request prescription refills
- Request appointments

PLEASE PRINT AND FILL IN ALL SPACES BELOW:

First Name: _____ Last Name: _____

Date of Birth: _____ Zip Code: _____

E-Mail: _____

****The email address provided will be your username****

Please check this box if you have an **existing** FollowMyHealth Account. We will send you a connection invite instead of creating a new account for you.

I herewith authorize North Shore Gastroenterology to create my FollowMyHealth (FMH) patient portal account and agree to all its terms and conditions. A copy of these agreements will be in my patient portal account.

Patient Signature: _____ Date: _____