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@northshoregastro.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!

North Shore Gastroenterology Associates, P.C.
233 East Shore Rd., Suite 101
Great Neck, NY 11023
Tel: 516-487-2444
Fax: 516-487-2446

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: _____

Local Pharmacy Name: _____ Phone: _____
Address: _____
Mail Away Pharmacy (if applicable): _____

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: _____

NORTH SHORE
Gastroenterology Associates

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 Sleep Apnea

☐ 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, NSAIDS (Motrin, Advil, Aspirin, etc.),vitamins/supplements, minerals, herbs. If additional space is needed, please attach a separate sheet):

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

Do you have any allergies? If so, please list them: _____
Do you have any allergies to soy, nuts or eggs? ☐ Yes ☐ No Please 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 #: _____

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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

NORTH SHORE
Gastroenterology Associates

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

NORTH SHORE Gastroenterology Associates

FollowMyHealth® Universal Health Record

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: _____