GASTROENTEROLOGY CONSULTANTS OF NORTH JERSEY

Patient information	
Patient Name:	Date of birth: / /
Street Address:	Gender: □ Male □ Female
City, State, Zip:	Weight: Height:
Home telephone:	Marital Status: S M Div Sep Wid
Alternate ph number: Work / Cell	SS#
E-mail Address:	
Name of Legally Responsible Representative:	
Relationship to Patient: spouse child partner other ***A copy of Power of Attorney must be on file, if one exists.	
Street Address:	
City, State, Zip:	Telephone:

Insurance Information	
Company Name:	Primary insured Social Security #:
Name of primary insured:	ID number:
Claims Address:	Group number:
City, State, Zip:	Company Telephone:

Referring Physician Information	
Physician Name:	Is this the primary caregiver? □ Yes □ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History *** please use back of form if more space is needed		
ALLERGIES: (list all meds and reactions)		
List all Present Illnesses/ Recent Diagnosis:		
Have you ever had an endoscopic procedure? □ Yes □ No	Reason:	Date:
Past Medical History:		
Past Surgical History:		
CURRENT MEDICATIONS: (***list all medications including the dosage and frequency of use; include any vitamins/supplements/over the counter medication and herbals):		
Do you take any of the following medications? Coumadin/ warfarin Plavix Aspirin NSAIDs Other:		
Do you have a personal or family history of any of the following? (***If other than self, please describe the relationship to the patient.)		

Abdominal Pain/ cramps	□Yes	□ No	Heart Disease	□Yes	□No
Acid reflux/ heartburn	□	□	Hepatitis	□	□
Anemia	□	□	High Blood Pressure	□	□
Asthma or Lung Disease	□	□	High Cholesterol	□	□
Cancer (type)	□	□	Irritable Bowel Syndrome	□	□
Constipation	□	□	Kidney problems	□	□
Crohn's disease	□	□	Mitral Valve prolapse	□	□
Diabetes	□	□	Nausea/ Vomiting	□	□
Diarrhea	□	□	Osteoporosis	□	□
Digestive disease	□	□	Polyps	□	□
Gastrointestinal Bleeding	□	□	Ulcers	□	□
GERD	□	□	OTHER:	□	□

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physician.

By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me**: Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; DNR policy; Notice of Privacy Practice.**

_____ _____ _____

Signature of Patient or Responsible Party Printed Name Date