ESSEX-HUDSON
GASTROENTEROLOGY
SPECIALISTS IN GASTROENTEROLOGY AND LIVER DISEASES

**5 Franklin Avenue, Suite 109**
**Belleville, NJ. 07109**
**Phone 973-759-7240 Fax 973-759-7243**

**Robert Spira, MD | Joseph DePasquale, MD| Etan Spira, MD | Youssef Botros, MD**

# PATIENT FOLLOW-UP - PAPERWORK INSTRUCTIONS

**Please be sure to have these items with you on the day of your appointment:**

- Photo ID (ex: Driver's License, Passport)
- Insurance Card
- Referral if needed *(Please check with your primary physician or insurance company – **if required by your insurance company*** **YOU CANNOT BE SEEN WITHOUT IT.**
- Any records pertaining to your visit (ex: bloodwork, radiology, and records from any previous procedures)
- All required paperwork completed:
    - Registration Form
    - Health History Questionnaire
    - Notice of Privacy Practices Acknowledgement Form
    - Consent for Use and Disclosure Form
    - Communication with Family/Caregivers Form

If you have any questions, please feel free to contact us.

Thank You

# REGISTRATION FORM

**ESSEX GASTROENTEROLOGY ASSOCIATION**
**5 Franklin Avenue - Suite 109, Belleville, NJ 07109**
**Phone: 973-759-7240 Fax: 973-759-7243**

Today's date:_____

## PATIENT INFORMATION

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Patient's Last name: First: Middle: | | | | | Social Security #: | | Marital status (circle one) Single / Mar / Div / Sep / Wid | |
| Race/Ethnicity: ❑ White ❑ Asian | ❑ American Indian | ❑ African American | ❑ Hawaiian/Pacific Islander | ❑ Hispanic | | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: | | | | | Home phone no.: ( ) | | Cell phone no.: ( ) | |
| City: | State: | ZIP Code: | | E-Mail: | | | | |
| Occupation: | Employer: | | | | | | Employer phone no.: ( ) | |
| Work Address/City/State/Zip Code: | | | | | | | | |
| Primary Doctor: | | | | | Phone no.: ( ) | | | |
| Address/City/State/Zip Code: | | | | | | | | |
| Referring Doctor: | | | | | Phone no.: ( ) | | | |
| Address/City/State/Zip Code: | | | | | | | | |
| Pharmacy Name: | | | | | Pharmacy Phone Number: | | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| | | | |
|---|---|---|---|
| Primary Insurance Name: | | Policy Number: | |
| Name of Subscriber: | | | Birth date: / / |
| Secondary Insurance Name: | | Policy Number: | |
| Name of Subscriber: | | | Birth date: / / |
| Guarantor's Name: (If other than Patient) | | | |
| Name of Subscriber: | Subscriber's Social Security #: | | Birth date: / / |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
| Address/City/State/Zip Code: | | | |

I authorize Dr. _____to furnish information to insurance carriers concerning my illness and treatment, and I assign the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

_____ _____

*Patient/Guardian signature* *Date*

# PATIENT FOLLOW-UP FORM

**Please help us by updating the following information:**

| **Name** *(Last, First, M.I.):* | **Today's date** |
|---|---|
| **Reason for your visit today:** | |


## Essex-Hudson Gastroenterology Associates

**5 Franklin Avenue, Suite 109**
**Belleville, NJ 07109**
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**Fax: 973-759-7243**


| **List current medications (include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers):** | | |
|---|---|---|
| **Name of Drug** | **Strength/Dose** | **Frequency Taken** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Allergies to medications** ☐ **No** ☐ **Yes (if yes, indicate below)** | |
|---|---|
| **Name of Drug** | **Reaction You Had** |
| | |
| | |
| | |
| | |

| **ANY CHANGES IN YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT: (PLEASE EXPLAIN)** | | |
|---|---|---|
| | | |
| **Heart Disease** | ☐ **Yes** | ☐ **No** |
| **Diabetes** | ☐ **Yes** | ☐ **No** |
| **High Blood Pressure** | ☐ **Yes** | ☐ **No** |
| **Cholesterol** | ☐ **Yes** | ☐ **No** |
| **Diabetes** | ☐ **Yes** | ☐ **No** |
| **Other:** | | |
| **FEMALE PATIENTS ONLY - Date of your last Mammography:** | | |

**PATIENT SIGNATURE:**

| |
|---|
| **Date:** |