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

SAME DAY PROCEDURES PAPERWORK INSTRUCTIONS

In order for our office to book your procedure properly, it is your responsibility as a patient to do the following:

- Fill out the Health History Form and all the paperwork completely
- Make copies of your insurance card – FRONT AND BACK
- Make a copy of ONE PHOTO ID (ex: Driver's License, Passport)
- Make copies of referral by PCP or insurance company

Please note that we cannot authorize or schedule your procedure if you are missing any of these documents.

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*

Essex Gastroenterology Associates

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

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**Birthdate:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Referring doctor:			
Current Occupation:			

PERSONAL HEALTH HISTORY

Reason for your visit today:

Please indicate if you are having any *current* problems or symptoms in the following areas:	☐ Eyes	☐ Muscular
	☐ Skin	☐ Joints
	☐ Ears, Nose, Throat	☐ Bones
	☐ Stomach/Digestion	☐ Neurological
	☐ Lungs/Breathing	☐ Allergies
	☐ Heart	☐ Reproductive
	☐ Circulation	☐ Thyroid/Endocrine
	☐ Blood	☐ Psychiatric
	☐ Lymph	☐ Urinary

List any medical problems that other doctors have diagnosed:

Surgeries/Hospitalizations

Year	Reason	Hospital

Please go to page 2

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**

Please go to page 3

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Women Only	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you or any family member have a history of any of the following:		
Cancer If yes, indicate site:	☐ **Yes**	☐ **No**
Heart Disease (Heart Attack/Heart Failure)	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**
Stroke	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
Other:		

PATIENT SIGNATURE:

Date:

NORTHFIELD SURGICAL CENTER
PRE-PROCEDURE QUESTIONNAIRE

Name: _____ **Date of Procedure:** _____

Age: _____ **Height:** _____ **Weight:** _____

Procedure: ☐ EGD ☐ Colonoscopy ☐ Pain Management ☐

REASON for the procedure:

MEDICAL HISTORY MARK THE BOX ONLY IF YOU HAVE/HAD ANY OF THE CONDITIONS BELOW:

☐ NO HISTORY	☐ Cancer	☐ COPD	☐ Heart Attack	☐ HIV Testing	☐ Liver disease
☐ Angina	☐ CHF	☐ Diabetes	☐ Heart Murmur	☐ Hyperlipidemia	☐ Prostate
☐ Asthma	☐ Cholesterol	☐ Emphysema	☐ Heart Valve	☐ High BP	☐ Sleep Apnea
☐ Atrial Fib	☐ Colitis	☐ Epilepsy	☐ Hemophilia	☐ Irritable Bowel	☐ Stroke (CVA)
☐ Coronary Artery	☐ Crohn's	☐ GI Ulcer	☐ Hemorrhoids	☐ Kidney disease	☐ TIA
☐	☐	☐	☐ Hepatitis	☐	☐ Thyroid

ALLERGIES (include Medications/Food/Contact (powder)/Latex (balloons, rubber gloves, bananas, avocados, potatoes)

Allergic to:	Reaction	Allergic to:	Reaction	Allergic to:	Reaction
☐ None Known	NA				

CURRENT MEDICATIONS (Include over-the-counter, vitamins, herbal, supplements, alternate medicines)

Medication/Dose/Frequency	Medication/Dose/Frequency	Medication/Dose/Frequency

Surgery/Previous Hospitalization: Write in the Date Done and Name of Procedure or Surgery

1.	4.	7.
2.	5.	8.
3.	6.	9.

Did you or any relatives ever have a reaction to sedatives or anesthesia? ☐ No ☐ Yes:

Implants?: ☐ None ☐ Pacemaker ☐ ICD ☐ Knee ☐ Hip ☐ Heart Valve Surgery ☐ Dentures ☐ Loose Teeth ☐ Hearing Aid

Smoke? ☐ No ☐ Yes...Packs a day Alcohol? ☐ No ☐ Yes Street Drugs? ☐ No ☐ Yes

Any religious/cultural/dietary restrictions? ☐ No ☐ Yes:

Advance Directives for Health Care: ..... ☐ No ..... ☐ Yes If yes, bring copy on day of admission

TRANSPORTATION ARRANGEMENTS

You will be sedated during your procedure. You must not drive yourself home. Therefore, please make arrangements for someone to drive you home. As an alternative, your escort may accompany you home in a taxi. This rule is for your safety and is strictly enforced. Anyone scheduled after 3:00PM should have the driver/escort stay and wait at the Center.

Your signature below acknowledges that you understand and agree to this rule.

PATIENT SIGNATURE: _____

☐ Prepared by Patient; Reviewed and verified (or modified) by RN

Nurse Signature: _____ Date: _____ Time: _____

NORTHFIELD SURGICAL CENTER PATIENT REGISTRATION/BOOKING FORM

□ DePasquale □ Spira □ Belleville □ Newark □ Orringer □ Gilder
□ Ruffini □ Stefaniwsky □ Fishbein □ Eagle □ Franzese □ Fiske □ Green

PROCEDURE INFORMATION

Procedure Date: _____ Time: _____
Procedure □ EGD □ Colonoscopy □ _____
DIAGNOSIS: _____
PRIMARY Physician or Referring MD (Full Name Please): _____
Antibiotics pre-op: □ Gentamicin 80mg IVPB □ Ampicillin __1Gm OR 2GM IVPB □ _____

PATIENT INFORMATION

Name: (LAST) _____, (FIRST) _____ (MI) _____
Address (Street/City/State/Zip): _____
Home Phone: _____-_____-_____ Work/Cell Phone: _____-_____-_____
Date of Birth: _____-_____-_____ Age: _____ Social Security#: _____-_____-_____
Sex: □ Male □ Female Marital Status: M S D W
Race/Ethnicity: □ Afric Amer □ Amer Indian □ Asian □ Hawaiian/Pacific Island □ Hispanic □ White □ _____
Emergency Name: _____ Phone: _____ Relation: _____

INSURANCE INFORMATION

Primary Insurance Co.: _____ Phone: _____
Policy number: _____ Group Number: _____
Address: _____
Pre-Authorization#: _____ Referral#: _____
Effective/Active Date: _____ Co-pay Due: Y N Co-pay Amount: $ _____
Deductible Met: Y N Deductible Amount: $ _____
Notes: _____

Secondary Insurance Co.: _____ Phone: _____
Policy number: _____ Group Number: _____
Address: _____
Pre-Authorization#: _____ Referral#: _____
Effective/Active Date: _____ Co-pay Due: Y N Co-pay Amount: $ _____
Deductible Met: Y N Deductible Amount: $ _____
Notes: _____

Guarantor's Name: □ Same as Patient
Name (if other than patient - Last, First): _____
Address (Street/City/State/Zip): _____
Home Phone: _____ Social Security#: _____ Date of Birth: _____

PATIENT EMPLOYER

□ Retired □ Student □ Unemployed Business Phone: _____
Name & Address of Company: _____

Booking Information Taken By (initials): _____ Date: _____ Time: _____
Registered By (initials): _____

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48 HOUR CANCELLATION/RESCHEDULING POLICY FOR SAME DAY PROCEDURES

You have been given an hour appointment for your same day procedure.

Date:_____ Time:_____ Place:_____

Because procedures require coordination between our patient's schedules and the availability of the physician and facility, we ask that, in the event you need to cancel or reschedule your procedure, you notify our office no later than **48 hours before** your scheduled procedure. This will allow the office to give your allotted time to other patients waiting for an appointment. Unless you notify our office of a cancellation or need to reschedule at least **48 hours before** your scheduled test, **a fee of $100.00** (one hundred dollars) will be billed to your account. **This fee is your personal responsibility and is not eligible for reimbursement by health issuers.**

Thank you for your anticipated cooperation.

I **acknowledge that** I **have read and agree to the cancellation/rescheduling policy.**

_____
Patient's Name

_____
Patient's Signature

Date: _____

Witness:_____