PATIENT REGISTRATION

Name: _____ Date of Birth: _____

Address: _____ City,State,Zip: _____

Phone (Home): _____ Work: _____ Employer: _____

Social Security: _____ Primary Care Doctor: _____

Martial Status: S M W D SEP Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Social Security: _____

Spouse's Insurance Information: _____

Emergency Contact: _____ Relation: _____

Address: _____ Telephone: _____

****

Payment required at the time of service unless prior arrangements have been made

****

1. INSURANCE COMPANY: _____

   ADDRESS: _____

   SUBSCRIBER'S NAME: _____ ID#: _____

   GROUP #: _____ PHONE: _____

   DEDUCTIBLE REQUIREMENT: _____ CO-PAYMENT: _____ CO-INS: _____

2. INSURANCE COMPANY: _____

   ADDRESS: _____

   SUBSCRIBER'S NAME: _____ ID#: _____

   GROUP #: _____ PHONE: _____

   DEDUCTIBLE REQUIREMENT: _____ CO-PAYMENT: _____ CO-INS: _____

MEDICARE #: _____ **MEDICAID #:** _____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance carrier to make direct payment of surgical/medical benefits to Jay E. Weissbluth, MD for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that it is my responsibility to obtain any referrals required by insurance prior to the time of service. If the referral is not obtained prior to the date of service, I am aware that I may be responsible for charges incurred.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Jay E. Weissbluth, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE – MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Jay E. Weissbluth, MD. A photocopy of these assignments shall be valid as the original.

PATIENT (PLEASE PRINT): _____ **DATE:** _____

PARENT/GUARDIAN (PLEASE PRINT): _____ **SIGNATURE:** _____

Name: _____ **Date:** ____/____/____

Medication	Dose	Frequency

Pharmacy: _____

Pharmacy#: _____

Allergies & Reactions: _____

GASTROENTEROLOGY HISTORY & PHYSICAL

NAME _____

DATE _____ DATE OF BIRTH _____

ADDRESS _____ OCCUPATION _____

_____ INSURANCE _____

PHONE (HOME) _____ PHONE (WORK) _____

SS# _____

FAMILY HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Pancr.	☐	☐	☐	☐	☐	☐
P. U. D.	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

Other _____

MEDICAL HISTORY

- ☐ Abdominal Pain-Chronic
- ☐ Anal Pain
- ☐ Anemia ☐ Bruise Easily
- ☐ Arthritis/Rheumatism
- ☐ Asthma/Wheezing
- ☐ Blood In Urine
  - Urination- ☐ Overnight >than twice ☐ Painful ☐ Loss of Control ☐ Decrease in Force/Flow
- ☐ Bronchitis/Chronic Cough
- ☐ Cancer
- ☐ Change in Bowel Habits
- ☐ Chest Pain
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Convulsions/Seizures
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Diarrhea ☐ Constipation
- ☐ Difficulty Swallowing
- Females- *Please Complete*
  - Pregnant? ☐ Yes ☐ No
  - Planning Pregnancy? ☐ Yes ☐ No
  - Menstrual Flow:
  - ☐ Regular ☐ Irregular ☐ Pain/Cramps
  - ____ Days Flow ☐ Length of Cycle
  - Date _____ 1st day of last period
- ☐ Diptheria
- ☐ Diverticulosis
- ☐ Dizziness/Fainting
- ☐ Enema use
- ☐ Fistula
- ☐ Frequent Infections
- ☐ Gall Bladder Trouble
- ☐ Gout
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Indigestion or Heartburn
- ☐ Jaundice/Hepatitis
- ☐ Kidney Stones
- ☐ Lactose Intolerance
- ☐ Loss of Appetite
- ☐ Mental Illness
- ☐ Nausea/ Vomiting
- ☐ Nose Bleeds
- ☐ Pancr.
- ☐ Peptic Ulcers
- ☐ Prostate Disease
- ☐ P. U. D.
- ☐ Sexual/Menstrual Dysfunction
- ☐ Stools
  - ☐ Blood ☐ Mucus
  - ☐ Pus ☐ Incont. ☐ Nocturn
- ☐ Tenesmus
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Disease
- ☐ Urethral Discharge
- ☐ Urine Infections- *Frequent*
- ☐ Varicose Veins/Phlebitis
- ☐ Weight Loss- *Recent*

CURRENT SYMPTOMS

- ☐ Abd. Pain
- ☐ Anal Pain
- ☐ Belching
- ☐ Bloating
- ☐ Diarrhea ☐ Constipation
- ☐ Fever
- ☐ Gas
- ☐ Gout
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea/ Vomiting
- ☐ Regurg.
- ☐ Weight Loss
- ☐ Other _____
- ☐ Change in Bowel Habits
- ☐ Stools
  - ☐ Blood ☐ Mucus
  - ☐ Pus ☐ Incont.
  - ☐ Nocturn

DRUG ALLERGIES

MEDICATIONS

HOSPITALIZATION OR SURGERY

Date	Reason	Date	Reason

HABITS

- ☐ Alcohol: Type _____ Amount _____
- ☐ Diet: Salt Intake _____ Fat Intake _____ Other _____
- ☐ Sleep: Difficulty Falling Asleep _____ Continuity Disturbances _____ Early Morning Awakening _____ Daytime Drowsiness _____ Other _____
- ☐ Smoke: Packs Daily _____ How Long _____ Interested in Stopping? _____
- ☐ Exercise Routine: _____
- ☐ Coffee: Cups Daily _____ Other Caffeine _____
- ☐ Lift Excessive Weight >25 lbs./day

MFR91103

JAY E. WEISSBLUTH, MD
3019 Avenue U
Brooklyn, NY 11229
Tel: (718) 934-1800 * Fax: (718) 891-5208

NOTICE OF PRIVACY PRACTICES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, orally, are kept confidential.

With my consent, DR. JAY E. WEISSBLUTH, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to my Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of my privacy practices can be obtained upon requesting.

With my consent, DR. JAY E. WEISSBLUTH or employee's of, may call my home or other designated location and leave a message on a voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

I have the right to request that DR. JAY E. WEISSBLUTH restrict how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

by signing this form, I am consenting to DR. JAY E. WEISSBLUTH'S use and disclosure of my protected health information and to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing, except to the extent that the practice has already made disclosure and reliance upon my prior consent. If I do not sign the consent, Dr. Jay E. Weissbluth may decline to provide treatment to me.

Signature of Patient: _____ Date: _____

JAY E. WEISSBLUTH, MD
3019 Avenue U
Brooklyn, NY 11229
Tel: 718-934-1800 Fax: 718-891-5208
Email: pgudavalli@usa.net

Date: _____

Patient: _____

DOB: _____

This is my written acknowledgement that I have received the Notice of Privacy Practices.

Signature: _____

I give my authorization to release my confidential information to the following:

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Jay E. Weissbluth, M.D.
.Diplomat, American Board of Internal Medicine
Practice Limited to Gastroenterology
3019 Avenue U * Brooklyn, NY 11229
Tel: (718) 934-1800 * Fax: (718) 891-5208

Dear Managed Care Patient,

We appreciate your confidence in choosing our practice for your medical care. Please take a moment to review our financial policy.

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up with each program's provision and changes.

- If you are an enrollee of a managed care plan that we are contracted with, you are required to pay the co-payment each time you are seen. **The co-pay must be paid at time of visit.**
- Some plans also have an annual deductible. You are required to pay this at the time of service. In the event that there is a balance due from you after your insurance carrier has paid its portion, we will bill you. If you do not understand the reason you owe a balance, please do not hesitate to contact our billing department.
- If your insurance requires a referral from your primary care physician, you must have the referral or electronic reference number with you in order to be seen. If you arrive with no referral, you must reschedule.
- If you agree to be seen without a referral, it will be your responsibility to obtain it from your PCP. If we do not receive the proper form promptly, you will become responsible for full payment for services provided.

IT IS YOUR RESPONSIBILITY TO KNOW:

- Whether this office is participating with your particular plan and program.
- To advise this office of your program's requirements in advance, each and every time we provide service.
- To advise this office of the insurance company that you have at each visit, even if it is the same as your last visit.

Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or use a facility that is outside of the program, you will be responsible for the appropriate fees.

Our staff is dedicated to working with you and your insurance carrier to process your claim. We appreciate your assistance in working with our staff and your insurance carrier.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a manual and a phone number for you to use if you have any questions about your coverage.

I have read the above and understand my obligations and knowledge receipt of this information.

Signature_____ _____ Date_____