Gastroenterology Associates, PC
106 Charles Lindbergh Blvd., Suite B, Uniondale, NY 11553

Patient Information Form

Name: _____ **Date:** _____ **Sex:** _____

Address: _____ **Date of Birth:** _____ **Age:** _____

City/State: _____ **Zip:** _____ **SS #:** _____

Marital Status: ☐Married ☐Divorced ☐Widow(er) ☐Single **E-Mail:** _____

Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____

GOVERNMENT MANDATED QUESTIONS ***Please Answer ALL 3 Questions***

Ethnicity (circle 1): Hispanic / Non-Hispanic **Preferred Language:** _____

Race (circle 1): American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander White Other

How did you hear about us? : ○*Website/Online* ○*Physician Referral* ○*Friend/Family Member* ○*Already a patient*

Pharmacy Name, Telephone #, & Address: _____

_____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Patient's Employer/School: _____ **Phone #:** _____

Employer/School Address: _____

Primary Care Physician: _____ **Address:** _____ **Phone #:** _____

Referring Physician: _____ **Address:** _____ **Phone #:** _____

Primary Insurance

Policy Name: _____
Policy Holder: _____
Relationship to Policy Holder: _____
Date of Birth of Policy Holder: _____
Policy #: _____ **Group #:** _____

Secondary Insurance

Policy Name: _____
Policy Holder: _____
Relationship to Policy Holder: _____
Date of Birth of Policy Holder: _____
Policy #: _____ **Group #:** _____

- ✓ I hereby authorize payment of medical benefits billed to my insurance to Gastroenterology Associates, PC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance.
- ✓ I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

_____ _____
Signature of patient or guardian **Date**

Patient Preferences Regarding their Protected Health Information

Patient Name: _____ **Date:** _____

Patient Contact Information

Location	Can We Call Here?	Can We Leave a Message?
Home	☐ Yes ☐ No	☐ Yes ☐ No
Cell	☐ Yes ☐ No	☐ Yes ☐ No
Work	☐ Yes ☐ No	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No

Mail Communication Preferences:

May we send mail to your home address? ☐ Yes ☐ No
If no, please provide an alternate mailing address: _____

E-Mail Communication Preferences:

I give consent to receive e-mails and to be placed on our e-mailing list: ☐ Yes ☐ No

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? Please fill in all that apply:

Name	Relationship	Telephone Number

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons: _____
_____

- ✓ I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.
- ✓ I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____
Printed Name **Date**

_____ _____
Patient or Personal Representative Signature **Relationship to Patient**

Gastroenterology Associates, PC
Consent for Release of Information for Treatment, Payment, and Health Care Operations

I, _____, hereby authorize **Gastroenterology Associates, PC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Gastroenterology Associates, PC** can refuse to treat me.

I have been informed that **Gastroenterology Associates, PC** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Gastroenterology Associates, PC**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Gastroenterology Associates, PC** took before receiving my revocation.

I understand that **Gastroenterology Associates, PC** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request the **Gastroenterology Associates, PC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Gastroenterology Associates, PC** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Gastroenterology Associates, PC** must adhere to such restrictions.

_____

Printed Name of Patient or Patient's Representative

_____

Relationship to the Patient

_____ _____

Signature of Patient or Patient's Representative **Date**

(Form MUST be completed before signing)