GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

Date: _____

PATIENT REGISTRATION INFORMATION

PLEASE PRINT

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. _____ Previous Name: _____
CHOOSE ONE↑ LAST NAME FIRST NAME MI (E.G., MAIDEN NAME)

Address: _____
STREET ADDRESS CITY STATE ZIP

Phone – Home _____ Cell: _____ Work: _____ ext _____

Ethnicity: _____ Race: _____

Primary Care Provider: _____ Referring Provider _____
NAME AND CITY (if different than PCP) NAME AND CITY

Patient date of birth: _____ ❑ M ❑ F ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated SS #: _____ –____–____

Patient employed by: _____

Business Address: _____
❑ Full time ❑ Part time ❑ Not employed ❑ Self employed ❑ Retired ❑ Active Military Duty ❑ Full time student ❑ Part time student

---

Responsible Party: _____ Phone: _____
(STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY) LAST NAME FIRST NAME MI

Address of Responsible Party: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Emergency Contact: _____ Phone: _____
LAST NAME FIRST NAME MI

Address of Emerg. Contact: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Name of Primary Insurance _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Policy Holder DOB: _____

Name of Secondary Insurance (if any) _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Patient's e-mail address: _____

Your local pharmacy name: _____ City: _____ Phone _____

Mail Order pharmacy name: _____ City/State: _____ Phone _____

Preferred Language: _____ Translator Required? ❑ Y ❑ N

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorize medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with those listed below.

Name	Phone Number	Relationship

Patient's home phone: ❑ OK to leave message with detailed information ❑ Do not leave details; leave message with callback number only

How did you learn of this practice? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ herby authorize _____
(name of insured) (name of insurance company)

to pay and hereby assign directly to *Practice Name* all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to *Practice Name*, PA will be credited to my account, in accordance with the above said

_____ _____
(authorized signature of subscriber) (date)

HEALTH HISTORY FORM FOR GASTROENTEROLOGY ASSOCIATES OF N.J

Today's Date _____ Patient's Name _____ Age _____ Referred by _____

GASTROINTESTINAL DISORDERS/SYMPTOMS

Upper GI	Explain any yes answers
Change in appetite	☐YES☐NO
Early satiety (feeling of fullness)	☐YES☐NO
Difficulty swallowing	☐YES☐NO
Indigestion/gas/belching	☐YES☐NO
Nausea/vomiting	☐YES☐NO
Heartburn/regurgitation	☐YES☐NO
Stomach pain (before or after meals)	☐YES☐NO
Ulcers	☐YES☐NO
Gallbladder disease	☐YES☐NO
Liver disease (jaundice,hepatitis, cirrhosis)	☐YES☐NO
Pancreatitis	☐YES☐NO
Lower GI	
Abdominal pain/cramping	☐YES☐NO
Gas/bloating	☐YES☐NO
Lactose intolerance	☐YES☐NO
Change in bowel habits	☐YES☐NO
Constipation	☐YES☐NO
Diarrhea	☐YES☐NO
Rectal bleeding/hemorrhoids	☐YES☐NO
Mucus in stools	☐YES☐NO
Fecal incontinence	☐YES☐NO
Inflammatory bowel disease	☐YES☐NO
Crohn's/ulcerative colitis	☐YES☐NO
Celiac Disease	☐YES☐NO
Irritable bowel syndrome/spastic colon	☐YES☐NO
Diverticulosis/diverticulitis	☐YES☐NO
Colon polyps	☐YES☐NO
Gastrointestinal cancer	☐YES☐NO

PREVIOUS GI TESTING (When and Where)

Blood tests _____
Stool tests _____
Abdominal x-rays or CAT scan _____
Upper GI series/barium swallow _____
Lower GI series/barium enema _____
Sigmoidoscopy _____
Colonoscopy _____
Upper Endoscopy _____
Gallbladder tests _____

OB HISTORY

Full Term____ # Miscarriages____ #Abortions_____

LIST MEDICATIONS & DOSAGE:

(continue on back if you need more space)

☐ No medications

Do you have any allergies (including medication, food environmental, and reaction to previous blood transfusion)
☐ YES ☐ NO If yes, describe:

Medical Conditions you have had and/or are being treated for: (i.e. heart disease, lung disease, hypertension, etc.) Continue on back if needed

SURGERIES/HOSPITALIZATIONS

Year/type continue on back if you need more space

☐ No Surgeries

Have you had any problems with anesthesia?
☐YES ☐NO If yes, please list:

PERSONAL HABITS:		
Tobacco	☐YES☐NO	____ pk/day
Alcohol	☐YES☐NO	____ oz/day/wk
Caffeine	☐YES☐NO	____ cups/day
Recreational drugs	☐YES☐NO	____ year started kind:

Family History:	Age	current or past medical conditions:		Age	medical conditions
Mother	____	_____	Sibling M/F	____	_____
Father	____	_____	Sibling M/F	____	_____
Sibling M/F	____	_____	Sibling M/F	____	_____
Sibling M/F	____	_____	Sibling M/F	____	_____

Indicate if your parents, brothers, sisters, and/or children have a history of:

Colon Polyps ☐	Pancreas Cancer ☐	Heart Disease ☐	Colon Cancer ☐	Ulcerative Colitis ☐
Hypertension ☐	Crohn's ☐	Stomach Ulcers ☐	Lung Disease ☐	Liver disease ☐
Stomach Cancer ☐	Diabetes ☐	Celiac Disease ☐	Kidney Disease ☐	Thyroid Disorder ☐

Signature _____ Reviewed by _____

GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

1130 McBride Avenue • 3rd Floor
Woodland Park, New Jersey 07424

Form F102

AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby authorize Gastroenterology Associates of New Jersey, LLC to use and/or disclose a copy of my medical records containing individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that, if the organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Person/Organization Providing the Information:

[Name of Patient or Representative_____
_____
_____

Person/Organization Authorized to Receive the Information:

_____
_____
_____

Specific and meaningful description of the information to be used and/or disclosed (such as dates of service or treatment, type of service or treatment, level of detail to be released or origin of information):

_____
_____
_____
_____
_____
_____

This medical information is being used and/or disclosed for the following purpose(s):

["At the Request of the Individual" is sufficient if the request is made by the patient and the patient does not want to state a specific purpose]

This Authorization shall remain valid and in effect until:

A) (MM/DD/YR): ____/_____/20_____ OR

B) The event that relates to the use and/or disclosure occurs and this Authorization is no longer necessary. This expiration event is _____

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I also understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is released to research or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

A signed copy of this Authorization must be given to the patient

GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

1130 McBride Avenue • 3rd Floor
Woodland Park, New Jersey 07424

N101
Gastroenterology Associates of New Jersey
Notice of Privacy Practices

Patient Name: _____ Date of Birth:_____

Date _____ / _____ / _____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

GANJ is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you and genetic information, and that relates to your past, present or future physical or mental health or condition and related health care services.

I hereby acknowledge that I have received from Gastroenterology Associates of New Jersey, LLC ("GANJ") a copy of the Notice o f Privacy Practices of GANJ. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how GANJ can use and disclose my personal health information both with and without my authorization. I further understand that I may contact GANJ's Privacy Officer if I have any questions regarding the contents of this Notice or to file a complaint.

_____
Signature of Patient/ Health Care Agent/ Guardian/ Relative
(This signature indicates having received a copy of the Notice of Privacy Practices.)

☐ Patient is unable to sign due to medical reasons
☐ Patient refuses to sign
☐ Other (Please Explain)

This Acknowledgement Form will become part of your permanent medical record.

GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

OFFICE FINANCIAL POLICY

All Patients must complete our Patient Information Sheet before seeing the doctor.

REGARDING MANAGED CARE INSURANCE WE PARTICIPATE WITH:
You are responsible to supply our staff with your identification cards and all referrals And / or authorization forms PRIOR to seeing the doctor (if applicable). THERE WILL BE NO EXCEPTIONS.

If you do not have proper forms, I.D. cards or applicable co-pays as described in your insurance handbook, YOU MUST EITHER RESCHEDULE OR PAY FOR THE SERVICES IN FULL.

REGARDING NON-PARTICIPATING INSURANCE:
It is your responsibility to understand which insurance plans your doctor is participating with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

REGARDING NON-PARTICIPATING INSURANCE'S "USUAL AND CUSTOMARY RATES":
Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our areas. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

REGARDING SECONDARY INSURANCE:
We are not responsible for submitting balances to your secondary insurance companies. We will gladly provide you the information you need to collect from your secondary insurance carrier.

RETURNED CHECK FEE: $50.00

Thank you for understanding our office financial policy. Please feel free to let our billing office know if you have any questions or concerns or if you need to discuss payment arrangements.

I have read the above office financial policy, I agree and understand its terms.

_____
Signature of patient or responsible party Date

_____
Signature of co-responsible party Date

GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

1130 McBride Avenue • 3rd Floor
Woodland Park, New Jersey 07424

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I,_____(print last name), _____(print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature _____ Date _____