Hackensack Meridian *Health*
Mountainside Medical Group
Pascack Valley Medical Group

Patient Registration

R. SWAMI NATHAN, M.D.,F.A.C.G.,P.A
OLEG SHULIK, M.D.
SAMEET SHAH, D.DO.
Verona Gastroenterology

Date: _____ **Patient Number:** _____

Name: _____ **DOB:** _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Home:** _____ **Preferred:** ☐

Marital Status: _____ **Cell:** _____ **Preferred:** ☐

Sex: _____ **Work:** _____ **Preferred:** ☐

Please select one

SS: _____ ☐ **Permission to text appointment reminders**

Race: ☐ **White** ☐ **Asian** ☐ **American Indian** ☐ **African American** ☐ **Other** ☐ **Refuse**

Ethnicity: ☐ **White** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Refuse**

Primary Language: ☐ **English** ☐ **Spanish** ☐ **Other** ☐ **Refuse**

Primary Pharmacy: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____

Secondary Pharmacy: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____

Emergency Contact: _____ **Patient's Relation to contact:** _____ **Phone:** _____

Patient's Care Team

(please furnish all current providers being seen within and out of this practice)

Physician's Name	Specialty or Condition Being Treated	Phone	Address
	Primary Care		
	Referring Doctor		

Hackensack Meridian *Health*

Employment Information

Employer: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____ **ZIP:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** _____

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

Secondary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** _____

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

Hackensack Meridian *Health*

Assignment of Benefits Authorization

I request that payment of authorized benefits be made to MPV New Jersey MD Services, PC for any service furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration ad its agents any information to determine these benefits payable for related services. This authorization may be canceled on my request any time.

Signature _____

Financial Policy

Thank you for choosing us for your medical care. The following is a statement of our Financial Policy which we ask you read and sign prior to any treatment.

All patients must complete our general information form and Medical History form before seeing the doctor. If you belong to an insurance or managed care plan, please let us know beforehand.

- We Accept cash, checks and credit cards.
- If you belong to an HMO or PPO that requires a co-payment, you will be asked to pay this prior to your seeing the doctor.

Regarding Medical Insurance…

Your health insurance policy is a contract between you and your insurance company. Any disputes regarding medical coverage should be addressed directly to them.

- ♦ If you belong to an HMO, PPO, or any other managed care plan in which we participate, we will automatically file your insurance claim for you. You are responsible for obtaining any required authorizations, pre certifications, and/or referrals prior to you visit.
- ♦ If a treatment or procedure is performed here and is deemed not payable by your insurance company (e.g. annual physicals, preventive immunizations, etc), you will be held responsible for payment in full.
- ♦ If you are a Medicare beneficiary, we will file your claim directly with Medicare for you, If you have secondary insurance, we will balance bill them for the portion Medicare does not pay, However, you will remain responsible for the annual deductible as well as any remaining co-payments. If you have a third insurance, you will be responsible for filing your own claims with them.

Patients Signature: _____ **Date:** _____

Print Name:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY OF PRACTICES

I, , have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

Patient's Number: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify) _____

****You May Refuse to Sign This Acknowledgement****

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE NOTICE)

Name: _____ **DOB**: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name	Relationship	DOB	Phone Number

☐ Information is not to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing

By signing this form you are acknowledging the release of information to all partners of Hackensack UMC Medical center, except our Gynecology office. You will be required to sign a second release form when seeing our gynecologists.

Signature: _____ Date: _____

Witness: _____ Date: _____

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YOUR MEDICAL HISTORY Date_____

Patient Name: _____ DOB: _____ Age: ___
(First) (Last)

Reason for visit: _____

_____

_____

Condition	Yes	No	**Condition**	Yes	No
DIGESTIVE SYSTEM	**Click box if YES**		***LIVER DISEASE (Continued)***	**Click box if YES**	
Difficulty Swallowing			Water in the Abdomen		
Painful Swallowing			Change in Stool Color		
Choking on Food			Receive Blood Transfusions before 1992		
Heartburn			Lupus		
Belching or Excess Gas			Liver Transplant		
Hiatal Hernia			***HEART DISEASE***		
Ulcer Disease			Chest Pain		
Nausea			Palpitation		
Vomiting			Heart Valve Disease		
Vomiting Blood			Irregular Heart Beat		
Rectal Bleeding			History of Heart Attack		
Black Stool			Heart Failure		
Abdominal Pain/Pressure			Difficulty in Breathing		
Pelvic Pain/Pressure			Hypertension		
Diarrhea			Pacemaker		
Constipation			Coronary bypass Surgery		
Unexplained Weight Loss			Angioplasty/Stent		
Unexplained Weight Gain			Do you take blood thinners?		
Hepatitis			Poor Circulation to Extremities		
Diverticulosis			***LUNG DISEASE***		
Colon Polyps			Difficulty in Breathing		
Colitis			Coughing		
Crohn's Disease			Chronic Bronchitis		
Pancreatitis			Emphysema		
LIVER DISEASE			Pneumonia		
Hepatitis A			Lung Cancer		
Hepatitis B			Asthma		
Hepatitis C			Wheezing		
Cirrhosis			***GENITOURINARY DISEASE***		
Iron Overload			History of Urinary Tract Infection		
Fatty Liver			Kidney Stones		
Liver Cancer			Blood in Urine		
Jaundice			Failing Kidney		
Gall Stones			Prostate Problems (Males)		
Bile Duct Obstruction			Frequent Urination		
Skin Itching			Dropped Bladder		
Intravenous drug use			Urinary Incontinence		

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Condition	Yes	No
NEUROPSYCHIATRIC	**Click box if YES**	
Headaches		
Convulsions		
Migraine		
Loss of Consciousness		
Numbness of Nerves		
Dizziness		
Depression		
Anxiety		
RENAL DISEASE		
Kidney Failure		
Dialysis/Hemo/Peritonial		
MUSCULAR / SKELETAL		
Joint Pain		
Joint Swelling		
Rheumatoid Arthritis		
Osteo Arthritis		
Back Pain		
Muscle Pain		
Spine or Disc Surgery		
ENDOCRINE DISEASE		
Diabetes		
Thyroid disorder		

FAMILY HISTORY

(Please indicate if mother or father's side)

Type of Disease	**Relationship**	**Age of Diagnosis**	**Age, if Deceased**
Colon cancer			
Colon Polyps			
Gastric Cancer			
Liver Cancer			
Breast Cancer			
Ovary Cancer			
Uterine Cancer			
Cervical Cancer			
Liver Disease			
Diabetes			
Ulcerative Colitis			
Celiac Disease			
Crohn's Disease			
Pancreatic Cancer			

Other significant family history, please explain:

_____

_____

_____

_____

_____

_____

HOSPITALIZATION HISTORY (recent inpatient/ER visit)

Date	Hospital/Type of Admission

PAST MEDICAL HISTORY

Please describe your current symptoms or complaints in this area. Also include any significant past medical history such as high blood pressure, diabetes mellitus, asthma, heart disease, or emphysema.

_____

_____

_____

_____

_____

_____

_____

_____

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PAST SURGICAL HISTORY

TYPE OF SURGERY	DOCTOR	YEAR	HOSPITAL

Other: _____

Did you have any of the following GASTROINTESTINAL procedures in the past?

Click circle if YES

		When	Where	Doctor
1) Colonoscopy	○ Yes ◉ No			
2) Endoscopy	○ Yes ◉ No			
3) Liver Biopsy	○ Yes ◉ No			
4) ERCP	○ Yes ◉ No			
5) CAT Scan(Abdomen)	○ Yes ◉ No			
6) Ultrasound(Abdomen)	○ Yes ◉ No			
7) Upper GI Barium X-Ray	○ Yes ◉ No			
8) Small Bowel Barium X-Ray	○ Yes ◉ No			
9) Barium Enema	○ Yes ◉ No			
10) MRI Abdomen(MRCP)	○ Yes ◉ No			

MEDICATION - Prescribed and Over the Counter (include vitamins, herbal medications,probiotics,etc)
(if you have a printed list with you, please give a copy to the front desk)

Name	Dosage	How Often?	How Long?	Name	Dosage	How Often?	How Long?

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL WORK? ○ **YES** ◉ **NO**

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SOCIAL HISTORY

Approximate Daily Caffeine Intake: (includes soda, tea, coffees) _____

Click circle if YES

Smoking: Y ◯ N ◉ How Much? _____ How Often? _____
years ____ If quit, when? _____

Alcohol: Y ◯ N ◉ How Much? _____ How Often? _____
years ____ If quit, when? _____

Drugs: Y ◯ N ◉ How Much? _____ How Often? _____
(including marijuana) # years ____ If quit, when? _____

Recent Travel: Y ◯ N ◉ Where? _____

FEMALES ONLY: Last menstrual period:_____ Last Mammogram: _____
Last pap smear:_____

ALLERGY HISTORY

Are you allergic to any of the following?

Medication

Y ◯ N ◉

Name of Medication	Reaction (i.e. rash, hives)	Name of Medication	Reaction (i.e. rash, hives)

Food

Y ◯ N ◉

Type of Food	Reaction (i.e. rash, hives)	Type of Food	Reaction (i.e. rash, hives)

IVP/CAT Scan dye Y ◯ N ◉ Reaction? _____

Latex Y ◯ N ◉ Reaction? _____

Lactose Intolerance Y ◯ N ◉ Reaction? _____

Dust/Mold/Pollen Y ◯ N ◉ Reaction? _____

Other Allergies:_____

YOUR HEALTHCARE PROVIDERS

Family Doctor: _____ Lung Specialist: _____

Cardiologist: _____ Other: _____

Signature _____ Date: _____

For Official Use Only

Reviewed by: Dr. Nathan / Dr. Shulik / Dr. Shah