GCNS
GASTROENTEROLOGY
CONSULTANTS OF THE NORTH SHORE

Type: _____
Date: _____
Location: _____
Prep: _____
Initials: _____

CONFIDENTIAL PATIENT INFORMATION

Demographics

Name (Last, First)		**Birthdate**	**Age**
Street Address		**City, State, Zip code**	
Martial Status S M W D SEP	**Primary Phone #**	**Alternate Phone #**	**SEX** **M F**
Email Address		**Social Security #**	
Name of Employer	**Work Phone #**	**Occupation**	

Insurance

Primary Insurance Company	**Group #**	**ID #**
Insurance Phone # and Address Including City, State and Zip (Not required if including a copy of the card)		
Subscriber's Name (Last, First) ***If other than Patient***	**Subscriber's DOB**	**Relationship**
Secondary Insurance Company	**Group #**	**ID #**
Insurance Phone # and Address Including City, State and Zip (Not required if including a copy of the card)		
Subscriber's Name (Last, First) ***If other than Patient***	**Subscriber's DOB**	**Relationship**

Referring Provider or Primary Care Physician	**Address**	**Phone #**
Other Physician	**Address**	**Phone #**

INSURANCE AUTHORIZATION AND ASSIGNMENT

1) All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is ultimately responsible for all fees, regardless of insurance coverage. For patients without insurance, it is necessary to make arrangements in advance with our account representative.

2) The patient authorizes and requests the insurance company to pay directly to GCNS insurance benefits otherwise payable to them.

3) The patient authorizes the release of any information including diagnosis and the records of any treatment or examination rendered to them during the period of such care to third party payors and/or health care practitioners.

This practice does not accept Medicare assignment. If the patient receives notification that Medicare denied payment for services ordered by the physician according to section 1862 (a)(1) of the Medicare Law, he or she agrees to be personally and fully responsible for the payment. The patient understands that if the claim is denied, he or she will receive a bill from GCNS.

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW A COPY OF THE GASTROENTEROLOGY CONSULTANTS OF THE NORTH SHORE'S PATIENT PRIVACY NOTICE

Patient Signature

Date

Patient Name: _____ Date of birth:_____

Please list any allergies:_____

Please list all prescription and over the counter medications you take below (including vitamins/supplements). If you need more room, please attach an additional sheet.

Medication	Dosage	Frequency	Reason

What is the reason for your current evaluation? _____

_____

Date of last colonoscopy: _____

Please list any surgeries: _____

_____

Have you ever smoked? _____ If so, have you quit? _____

Do you drink alcohol? _____ If so, how much/how often? _____

Is there a family history of digestive disease (colon cancer, polyps, colitis, ulcers, gallbladder disease, etc.)?

_____

_____

Please mark any of the following symptoms and please elaborate:

□ Constitutional (fever, weight loss, fatigue):_____

□ Eyes (changes in vision, redness, discharge):_____

□ Ear/Nose/Throat (sinusitis, hoarseness, change in voice):_____

□ Cardiovascular (chest pain, palpitations, poor circulation):_____

□ Respiratory (shortness of breath, wheezing, cough):_____

□ Hematologic (anemia, bleeding, bruising):_____

□ Endocrine (thyroid, osteoporosis, diabetes):_____

□ Gastrointestinal (diarrhea, constipation, abdominal pain):_____

□ Skin (rash, itching, change in color):_____

□ Genitourinary (discharge, pain, rash):_____

□ Musculoskeletal (weakness, muscle aches, joint aches):_____

□ Neurologic (stroke, seizure, weakness):_____

□ Psychiatric (depression, anxiety, hallucination):_____

□ **None of the above**

(GCNS) Physician Signature): _____ Date: _____