ESSEX-HUDSON
GASTROENTEROLOGY
SPECIALISTS IN GASTROENTEROLOGY AND LIVER DISEASES

5 Franklin Avenue, Suite 109
Belleville, NJ. 07109
Phone 973-759-7240 Fax 973-759-7243

Robert Spira, MD | Joseph DePasquale, MD| Etan Spira, MD | Youssef Botros, MD

PATIENT FOLLOW-UP - PAPERWORK INSTRUCTIONS

Please be sure to have these items with you on the day of your appointment:

- Photo ID (ex: Driver's License, Passport)
- Insurance Card
- Referral if needed *(Please check with your primary physician or insurance company – **if required by your insurance company*** **YOU CANNOT BE SEEN WITHOUT IT.**
- Any records pertaining to your visit (ex: bloodwork, radiology, and records from any previous procedures)
- All required paperwork completed:
  - Registration Form
  - Health History Questionnaire
  - Notice of Privacy Practices Acknowledgement Form
  - Consent for Use and Disclosure Form
  - Communication with Family/Caregivers Form

If you have any questions, please feel free to contact us.

Thank You

REGISTRATION FORM

ESSEX GASTROENTEROLOGY ASSOCIATION
5 Franklin Avenue - Suite 109, Belleville, NJ 07109
Phone: 973-759-7240 Fax: 973-759-7243

Today's date:_____

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Social Security #:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Race/Ethnicity: ❑ White ❑ Asian ❑ American Indian ❑ African American ❑ Hawaiian/Pacific Islander ❑ Hispanic	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

City:	State:	ZIP Code:	E-Mail:

Occupation:	Employer:	Employer phone no.: ( )

Work Address/City/State/Zip Code:

Primary Doctor:	Phone no.: ( )

Address/City/State/Zip Code:

Referring Doctor:	Phone no.: ( )

Address/City/State/Zip Code:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Name:	Policy Number:

Name of Subscriber:	Birth date: / /

Secondary Insurance Name:	Policy Number:

Name of Subscriber:	Birth date: / /

Guarantor's Name: (If other than Patient)		
Name of Subscriber:	Subscriber's Social Security #:	Birth date: / /

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Address/City/State/Zip Code:

I authorize Dr. _____to furnish information to insurance carriers concerning my illness and treatment, and I assign the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

Patient/Guardian signature *Date*

PATIENT FOLLOW-UP FORM

Please help us by updating the following information:

Name *(Last, First, M.I.):*	**Today's date**
Reason for your visit today:	

Essex-Hudson Gastroenterology Associates

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List current medications (include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers):		
Name of Drug	**Strength/Dose**	**Frequency Taken**

Allergies to medications ☐ **No** ☐ **Yes (if yes, indicate below)**	
Name of Drug	**Reaction You Had**

ANY CHANGES IN YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT: (PLEASE EXPLAIN)		
Heart Disease	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**
Cholesterol	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
Other:		
FEMALE PATIENTS ONLY - Date of your last Mammography:		

PATIENT SIGNATURE:
Date: