ESSEX GASTROENTEROLOGY ASSOCIATES, LLC
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5 Franklin Ave., Suite 109, Belleville, N.J. 07109
Phone 973-759-7240 Fax 973-759-7243

NEW PATIENT 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 and photo ID 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*