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

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
    - Patient Follow-up Form
    - *If it has been more than 6 months since you have been seen, you must fill out the following:*
        - Health History Questionnaire (this can be found on our website under the Forms tab in the New Patient Section

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*

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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:	

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: