BayRidge Gastroenterology

Patient Demographics Form

9920 Fourth Avenue, Suite 205,
Brooklyn, NY, 11209
718-745-8091
718-745-0623
bayridgegastroenterology.com
bayridgegastrodoc@gmail.com

Contact Information

Today's Date:

Patient Name (Please print)	Date of Birth	Last 4 digits of SS#

Race: ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White Non-Hispanic ☐ Other: ____________

Street Address	Apt. #	City, State and Zip Code

Email Address	Home Telephone#	Cellular #	Work # (if ok to call)

Please list method of contact in order of preference

Contact Information

Primary Insurance	Policy#
Secondary Insurance	**Policy#**

Primary insurance holder (if not yourself)	Date of Birth	Social Security Number

Do you have prescription coverage with insurance? ☐ Yes ☐ No

Pharmacy Information

Name	Address	Phone#

Emergency Information

Primary contact	Relationship	Telephone#
Secondary contact	**Relationship**	**Telephone#**

Your Gastroenterologist	Tel#
Primary Care Physician	**Tel#**

I attest that the above information provided by me is accurate

Signature of Patient

Date

Signature of Legal Guardian, Health Care Proxy, or Power of Attorney

Date

Welcome to our office! It is our pleasure and privilege to act as your health care provider. Please answer the following questions to the best of your ability so that we may better attend to your health care needs. All information will be kept confidential.

Medical History

Please let us know why you came to our office

Have you had a Colonoscopy in the past? ☐ Yes ☐ No

If Yes, when was the last one, and were any polyps or malignancy found? ____________________

Have you had any recent (in the past 1 year) or past problems with

	Recent	Past	No
Diabetes	☐	☐	☐
High blood pressure	☐	☐	☐
Heart attack	☐	☐	☐
Cardiac stents	☐	☐	☐
Pacemaker	☐	☐	☐
Abnormal heart rhythm	☐	☐	☐
	☐	☐	☐

	Recent	Past	No
Ulcers	☐	☐	☐
Liver Disease	☐	☐	☐
Heartburn/Acid Reflux	☐	☐	☐
Gallstones	☐	☐	☐
Blood clots	☐	☐	☐
Osteoporosis	☐	☐	☐
Chronic lung disease	☐	☐	☐

Please list any medical conditions, hospitalizations and surgeries (other than cancer) starting with the most recent, and the approximate year. You will have an opportunity to list cancers separately on the next page:

Do you smoke?

☐ Yes If yes, how many years have you been a smoker? ____________________ How many packs per day? ________

☐ No If no, were you ever a smoker? ☐ Yes ☐ No If you smoked in the past, when did you quit? ____________

Do you drink alcohol?

☐ Yes If so, what type of alcohol do you drink? ____________________ How many drinks per day? ________

☐ No

I am: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

With whom do you live?

What is/was your occupation?

Are you retired? ☐ Yes ☐ No

Cancer History

Personal history of cancer (YOURSELF) ☐ Yes ☐ No

	At what age, and how was it treated?
☐ Colon Cancer	
☐ Colonic Polyps	
☐ Stomach Cancer	
☐ Pancreatic Cancer	
☐ Liver Cancer	
☐ Ovarian Cancer	
☐ Breast Cancer	
☐ Prostate Cancer	
☐	

Family History of Cancer (BLOOD RELATIVES) ☐ Yes ☐ No

	Which relative, and at what age?
☐ Colon Cancer	
☐ Colonic Polyps	
☐ Stomach Cancer	
☐ Pancreatic Cancer	
☐ Liver Cancer	
☐ Ovarian Cancer	
☐ Breast Cancer	
☐ Prostate Cancer	
☐	

Your Preferences

☑ Do you give permission to discuss medical or financial information with anyone else (ex. family member/friend)? ☐ Yes ☐ No

If yes, whom? ______________________________

☑ Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

(If yes, this will be honored at any hospital).

☑ Do you have a Health Care Proxy? ☐ Yes ☐ No

If yes, whom? ______________________________

☑ Are there any Religious, Cultural, or Personal Beliefs that may preclude you from receiving advanced medical treatment, blood, blood products, etc.? ☐ Yes ☐ No

If yes, explain: ______________________________

I attest that the above information provided by me is accurate:

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Legal Guardian, Health Care Proxy, or Power of Attorney Date

For future visits only: I have reviewed the information previously supplied and it is unchanged from my last visit.

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Legal Guardian, Health Care Proxy, or Power of Attorney Date

BayRidgeGastroenterology

Patient Payment Agreement

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To Be Completed When Payment in Full is Not Rendered at the Time of Service

It is the policy of the BayRidge Gastroenterology (BRG) to require payment in full for all services at the time such services are rendered. In order to induce BRG to defer collection from me pending the initial processing of an insurance claim to be submitted to my insurance company ("Insurance"), I hereby agree as follows:

I accept and acknowledge full financial responsibility for all co-payments, deductibles, and fees associated with my treatment. I also accept and acknowledge full financial responsibility for all services provided to the extent not actually and timely paid to BRG by my Insurance.

I will take all actions and execute all documents necessary to assure that any payment to which I am entitled from my Insurance with respect to services provided by BRG doctors will be paid directly to BRG. If my Insurance makes payment directly to me or to my insured family member, I (and my insured family member when applicable, jointly) acknowledge that I (we) are responsible to immediately forward such payment and copies of any and all accompanying explanations of benefits to BRG.

I also acknowledge and agree that in the event that the co-payments and deductibles, as well as non covered services, (the "outstanding billings") are not paid at the time of the office visit and or procedure, these outstanding bills will begin to accumulate interest commencing 30 days after demand for payment, or 15 days after notification to BRG that my Insurance has made payment directly to me or my insured family member, whichever is earlier, at the monthly rate of 1.5%, simple interest (annual percentage rate ("APR") of 18%) and which interest will be added on to any unpaid balance. In the event that I or my insured family member receives direct payment from my Insurance, I will cause such payment to be immediately turned over to BRG. I further acknowledge that I (and my insured family member where applicable) will also be responsible for any costs and fees BRG may incur in enforcing this Agreement, which includes any and all reasonable attorney's fees which BRG may incur. I understand that I am free to consult with an attorney before signing this or any agreement.

Any dispute regarding the meaning and enforcement of this Agreement will be determined under New York law, without regard to conflicts of law principles, and will be exclusively resolved in a court of competent jurisdiction located in or having jurisdiction over Brooklyn, New York, and I hereby irrevocably submit to the personal jurisdiction of such court for purposes of enforcing this agreement.

Patient Signature ____________________ Date ____________________

Insured Signature ____________________ Date ____________________

Patient Name (PRINT) ____________________

Insured Name (PRINT) ____________________

Relationship to Patient (PRINT) ____________________

BayRidge Gastroenterology

Notice of Privacy Practices

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I, ______________________________, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions to the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature ____________________

____
Date