Vitaly Fishbein M.D., L.L.C.

Gastroenterology Evaluation for New Patients

Patient Name: ______________________ *DOB:* ____________ *M/F* *Date* ____________

Phone Number: ______________ *Referred By:* ______________________

History of Present Illness (Circle present symptoms)

Nausea/Vomiting	Abdominal pain	Weight changes: Loss/Gain	Abnormal lab results
Vomiting of blood	Difficulty swallowing of Solids/Liquids	Rectal pain	Abnormal imaging study
Heartburn/Indigestion	Black stool/Blood in stool	Jaundice	Recent antibiotic use
Acid brash	Diarrhea/Incontinence	Increased abdominal girth	
Nocturnal coughing or choking	Constipation	Food intolerance: Fats/Wheat/Grains	
Throat pain/Hoarsness	Change in stool quality/quantity	History of Heme+ stool	

Other,specify:

Please Describe Problem (Location, Type, Severity, Duration, Timing, Proximate factors, Mitigating factors, Associated Complaints)

____

____

Problem Status : New or Established (Stable/Improving/Worsening)

Review of Systems (Circle present symptoms)

Const:	Fever Chills Fatigue Change in appetite
Eyes:	Vision change Dry eyes
ENT/Mouth:	Nose bleeds Dentures Jaw pain
Heart:	Chest pain Palpitations Swelling in legs
Resp:	Cough Wheeze Shortness of breath
GU:	Change in urinary habits Blood in urine
	Kidney/bladder stones
MS:	Pain/ Stiffness/ Joint swelling Back pain
Heme/Lymph:	Bleeding Bruising Swollen lymph nodes
	Clotting problems
Endo:	Thirst Heat/Cold intolerance Night sweats
Allergy/Immune:	Sinus problems Recurrent infections
Skin:	Rashes Lesions Ulcers
Neuro:	Headaches Dizziness Seizures Muscle weakness

Social History:

Never Smoker

Smoker Y/N # Packs x # Yrs.

Ex-Smoker Y/N

Unwilling to quit/Consider quitting

Alcohol Y/N Daily/Socially

Occupation: Working/Retired

Allergies

Food Allergies Y/N If Yes, specify:

Drug Allergies Y/N If Yes, specify:

Other; specify

Did you ever have colonoscopy? Y/N If yes, when ______________________

List Current Medications

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Family Medical History

Asthma
Congestive Heart Failure
COPD
Coronary Artery Disease
Diabetes
Familial Mediterranean Fever
Hemochromatosis

Pancreatitis
Peripheral Artery Disease
Polyps Rectal/Colonic
Renal Dysfunction
Thrombotic Disorder
Thyroid Disease
Other, specify

Malignancy
- Colorectal
- Esophageal
- Breast
- Hepatic
- Melanoma
- Other,specify
- Lung
- Thyroid
- Prostate
- Testicular

Past Medical History

Achalasia
Antibiotic use
Arteriovenous Malformations
Autoimmune hepatitis
Barrett's esophagus
Budd-Chiari Syndrome
Carcinoid Syndrome
C. difficile Colitis
Celiac Disease
Cirrhosis
Colitis
Crohn Disease
Cystic Fibrosis
Diverticulitis
Diverticulosis
Esophageal Stricture
Esophageal Varices
Familial Mediterranean Fever
Cholelithiasis

Cholecystitis
Ischemic colitis
Hemochromatosis
Hemorrhoids
Hepatitis A
Hepatitis B
Hepatitis C
Hepatic dysfunction
Herpes
Hernia
Histiocytosis
HIV or AIDS
H. pylori positive
Inflammatory Bowel disease
Jaundice
Liver Disease
Malaria
Nonalcoholic Fatty Liver disease
Parasitic infections

Pancreatitis
Peritonitis
Polyps Rectal/Colonic
Sarcoidosis
Sclerosing cholangitis
Sickle Cell Disease
Thrombocytopenia
Tuberculosis
Ulcerative Colitis
Ulcers
VIPoma
Whipple's Disease
Wilson Disease
Zollinger-Ellison Syndrome
Malignancy:
- Breast Colorectal
- Hepati Esophageal
- Melan Lung
- Other, specify
- Thyroid
- Prostate
- Testicular

Surgical History

History of
- Colestomy: Full/Partial
- Esophageal Dilation
- Gastric Bypass
- Gastric volume reduction
- Liver biopcy: Malignant/Benign
- Other, specify

- Pancreatic stent
- PEG/PEJ tube
- Polypectomy: Malignant/Bening
- TIPS

Patient Signature ______________________________ ***Date:*** ______________

VITALY A. FISHBEIN, M.D., F.A.C.G.
Diplomate American Board of Gastroenterology

401 Pleasant Valley Way, West Orange, NJ 07052 • Tel: (973) 736-1112 Fax: (973) 736-5590 • www.gastrocure.com

Patient Registration Form

Name: ______________________________ Gender ☐ Male ☐ Female Date of Birth: __________
(Last) (First)

Address: ____
(Street) (City) (NJ) (Zip code)

Telephone: Home ________________ Cell: ________________ Work: ________________

Social Security # ______________ Marital Status: M/ S/ W/ D ***Email Address: ________________

Pharmacy Name: ________________________ Telephone: ________________

____
(Street) (City)

Primary Care Physician: ________________________ Office Telephone: ________________

Referring Physician: ________________________ Office Telephone: ________________

Primary Insurance: ______________________________

Primary Insurance ID#: ______________________________

Secondary Insurance: ______________________________

Insurance Card ID#: ______________________________

*****I understand and agree that (regardless of my insurance status). I am ultimately responsible for the balance of my account or any professional services rendered. I have read all the information on both pages and have completed the above answer. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.**

______________________________ ______________________________
(Signature of Patient or Legal Representative) (Date)

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FINANCIAL POLICY

The follow is a statement of your ***FINANCIAL POLICY.*** All patients ***MUST*** accept our ***FINANCIAL POLICY*** before receiving any medical treatment.

METHOD OF PAYMENT: We accept cash, credit cards, and checks. Payment plans may be arrange on an individual basis with the office manager prior to your doctor's appointment.
RTURNED CHECKS: A $25.00 service fee will be added to all checks returned for insufflate funds. ***If your check is returned you will be required to pre pay in full by CASH ONLY for additional services.***

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is ***your*** responsibility. Your insurance policy is a contract between you and your insurance company. ***You are responsiable*** for verifying if providers are in network with your insurance company. We cannot bill your insurance company unless you give us complete insurance information for commercial insurance and Medicare. It is ***your responsibility*** to know your insurance benefits; it may not cover all of the services provided to you. ***If your insurance require a referral it is your responsibility to obtain one.*** All co-pays are due prior to treatment.

DEFINITIONS:

CO-PAYMENTS: A fixed amount set by your insurance contract this is to be paid at the time of service . this amount can range from $5 to $50 per visit

DEDUCTIABLE: An annual dollar amount established by your insurance plan that is deducted from insurance benefits. ***This amount is your obligation and must be paid prior to health care service.***

CO-INSURANCE: A percent set by your insurance plan that is deducted from insurance benefits. This percent usually ranges between 10% and 30% and is ***your obligation to pay***.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY

X______________________ ______________________ ____________
(Signature of Patient or Legal Party) (Print Name) (Date)

HIPAA RIGHTS

I have received a copy of the notice of Privacy Practice and give permission to Vitaly A. Fishbein MD.LLC to use and disclose my health information in accordance with it.

X______________________ ______________________ ____________
(Signature of Patient/ Legal Party) (Print Name) (Date)

DISCLOSURE TO OTHERS

Please Check One:

☐Family members or friends are ***NOT*** to be given ***ANY*** of my medical information.

☐I give my permission for the persona(s) listed below to obtain and discuss with Dr. Fishbein and/or members of his staff my medical information to include; but not limit to, making appointments, discussing appointments, obtaining lab results, pathology results and radiology results.

1.______________________ 2.______________________

X______________________ ______________________ ____________
(Signature of Patient /Legal Party) (Print Name) (Date)