Naugatuck Valley Gastroenterology Consultants, LLC

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**PATIENT INFORMATION**

Patient's Name (Last, First and MI) _____

Address_____City_____State_____Zip_____

Home Phone (  ) _____Mobile Phone (  )_____Email_____

Date of Birth_____Sex _____Marital Status _____SS#_____

Referring Physician_____Last visit to Referring Physician _____PCP_____

Employer Name_____Phone (  ) _____

**INSURANCE INFORMATION**

Primary Insurance Name _____ ID# _____

Policyholder Name_____Relationship_____Date of Birth_____

Secondary Insurance Name_____ ID# _____

Policyholder Name_____Relationship _____Date of Birth _____

**SPOUSE/PARENT INFORMATION**

Spouse/Parent_____Date of Birth _____SS#_____

Spouse/Parent Employer Name_____Phone (  )_____

**EMERGENCY CONTACT**

Name_____Relationship_____

Home Phone (  ) _____Mobile Phone (  )_____

**PHARMACY INFORMATION**

Pharmacy Name_____Address _____City_____

Phone (  ) _____

**NOTICE:** PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT AND IS NOT A GUARANTEE OF PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERS PAY A PERCENTAGE OF THE CHARGES. IT IS YOUR RESPONSBILITY TO PAY FOR ANY DEDUCTIBLES, CO-INSURANCE, CO-PAYS, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY/COLLECTION AGENCY OR SUIT, THE PRACTICE IS ENTITLED TO REASONABLE ATTORNEY/COLLECTION FEES AND COURT COSTS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED TO BE VALID AS THE ORIGINAL. THE UNDERSIGNED UNDERSTANDS THAT THEY ARE FINANCIALLY RESPONSIBLE TO PAY FOR ALL CHARGES ACCORDING TO THEIR POLICIES AND PROVISIONS.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF ANY BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES REALIZING I AM RESPONSIBLE TO PAY FOR ANY NON COVERED SERVICES.
**AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO PROCESS INSURANCE CLAIMS.
**I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES AS INDICATED ON THIS FORM.**
**DISCLOSURE OF OWNERSHIP:** NAUGATUCK VALLEY ENDOSCOPY CENTER, LLC IS OWNED BY ROBERT LEVENTHAL, M.D., THOMAS ROCKOFF M.D., AND PAOLO MAPELLI, M.D.

**Signature**_____ **Date**_____
(THE CORPORATION RESERVES THE RIGHT TO DESIGNATE THE INDIVIDUAL TO PERFORM THE SERVICE ON ITS BEHALF)

**MEDICAL HISTORY FORM**

Name _____ Date of Birth_____ Age _____

Reason for today's visit _____

Height _____ Weight _____ Today's Date _____

**YOUR MEDICAL HISTORY (please check off all that apply)**

Have you had or currently have any heart problems (Stents, Pacemakers, Heart Attack) □ Yes □ No

Are you a diabetic? □ Yes □ No □ Insulin □ Pills

Are you being treated for High Blood Pressure? □ Yes □ No

Are you on any blood thinners (Coumadin, Warfarin, Plavix, Aggrenox, Pradaxa, etc.) □ Yes □ No

If yes who is your cardiologist? _____

Do you have any Kidney problems? □ Yes □ No

Are you allergic to eggs or soy? □ Yes □ No

Do you have or ever had Staph or a MRSA infection? □ Yes □ No

| | | | |
|---|---|---|---|
| □ Alcoholism/Drug Abuse | □ Anemia | □ Anxiety/Depression | □ Arthritis |
| □ Asthma/Emphysema | □ Bleeding Tendency | □ Bone Disease | □ Cancer/Tumor |
| □ Cirrhosis | □ Colitis | □ Crohn's Disease | □ Diverticulosis/Diverticuliti |
| □ Eating Disorders | □ Epilepsy / Seizure Disorder | □ Gallbladder Disease | Gastroesophageal Reflux |
| □ Glaucoma | □ Gonorrhea/Syphilis/Herpes | □ Heart Disease/Heart Failure | □ Hemorrhoids |
| □ HIV Infection / AIDS | □ Irritable Bowel Syndrome | □ Liver Disease | □ Jaundice/Hepatitis |
| □ Migraine Headaches | □ Peptic Ulcer Disease | □ Psychiatric Disease | □ Prostate Disease/Cancer |
| □ Stroke/TIA | □ Thyroid Disease | □ Tuberculosis | □ Ulcerative Colitis |
| □ Other _____ | | | |

**GASTROINTESTINAL**

| | | | |
|---|---|---|---|
| □ Abdominal Pain | □ Poor Appetite | □ Bloody/black stools | □ Chest Pain |
| □ Constipation | □ Cough/Hoarseness/Lump in throat | | □ Diarrhea |
| □ Gas/Bloating | □ Indigestion/Heartburn | | □ Nausea |
| □ Pain/Difficulty Swallowing | □ Rectal Pain | □ Vomiting | □ Weight Loss_____lbs (how much?) |

**OPERATIONS/SURGERY**

| | | | |
|---|---|---|---|
| □ Appendix | □ Colon/Small Intestine | □ Gall Bladder | □ Gastric Bypass/Lap band |
| □ Hemorrhoids/Fissure | □ Hysterectomy/Ovary | □ Kidney | □ Pacemaker/Defibrillator |
| □ Stomach | | | |

If you checked off any item above, please list the dates of each item checked. For any surgery please list dates and where the surgery was performed:_____

_____

_____

_____

_____

_____

**TESTING (Have you ever had any of the following? Please check off all that apply.)**

| | | | |
|---|---|---|---|
| □ Barium Swallow | □ CT Abdomen/Pelvis | □ MRI Abdomen/Pelvis | □ HIDA Scan |
| □ Ultrasound | □ Upper GI Series | □ Breath Testing | □ Capsule Endoscopy |
| □ Colonoscopy | □ ERCP | □ Liver Biopsy | □ Upper Endoscopy |

If you checked off any testing on the previous page, please list the dates and location where the testing was done:

Have you had any recent blood work / labs? □ Yes □ No

If yes, what kind and where was the blood work / labs done? _____
If yes, who ordered it & where was it done? _____

Have you had any stool testing / cultures? □ Yes □ No
If yes, what kind? _____

**SOCIAL HISTORY**

Do you or have you use(d) tobacco? □ Yes □ No

Do you or have you use(d) alcohol/drugs? □ Yes □ No

Do you drink caffeinated beverages? □ Yes □ No

Have you ever lived outside of the United States? □ Yes □ No Where _____ When _____

Have you received any blood transfusions? □ Yes □ No If yes was it before 1992? □ Yes □ No

**What is your race?**

□ American Indian or Alaska Native □ Asian □ African American □ White □ Native Hawaiian □ Other Pacific Islander □ More than one race □ No Response

**What is your ethnicity?** □ Hispanic or Latino □ Not Hispanic or Latino □ No Response

What is your preferred language? _____

Please list ALL ALLERGIES to medication or other substances: _____

Please list all of your current medications including alternative/herbal therapies with dosage, if you have a list we'll make a copy.

**FAMILY HISTORY (Has anyone in your family had any of the following below?)**

| | | | |
|---|---|---|---|
| □ Colitis | □ Breast Cancer | □ Colon/Rectal Cancer | □ Colon/Rectal Polyps |
| □ Crohn's Disease | □ Esophageal Cancer | □ Irritable Bowel Syndrome | □ Liver Cancer |
| □ Liver Disease/Hepatitis | □ Ovarian Cancer | □ Pancreatic Cancer | □ Peptic Ulcer Disease |
| □ Stomach Cancer | □ Ulcerative Colitis | □ Uterine Cancer | |

Please list below who in your family had any of the items checks below and at what age if known:

Is there any other information you want the doctor to know or are there any questions you may want the doctor to answer?