Name:_____ Date of Birth:_____ Today's Date:_____

Mercer Gastroenterology, 609-818-1900 Fax: 609-818-1908
New Patient Encounter Form

HISTORY – COMPLETED BY THE PATIENT, FAMILY, STAFF OR PROVIDER

Please fill out this form to the best of your ability.

1. Reason for your visit today:_____

_____

2. Medical History: Please check all that apply:

☐ GERD / Heartburn	☐ Heart Disease	☐ Diabetes
☐ Stomach Problems	☐ Pacemaker or Defibrillator	☐ Stroke
☐ Colon Cancer / polyps	☐ Atrial Fibrillation	☐ Asthma / Lung Disease
☐ Irritable Bowel Syndrome	☐ High Blood Pressure	☐ Kidney Disease
☐ Pancreatic Disease	☐ Elevated cholesterol	☐ Bleeding tendency
☐ Liver Disease	☐ History of Blood Clots	☐ Sleep Apnea

Any other Gastrointestinal disease, please specify _____

_____

Any other Medical illnesses, please specify_____

_____

3. Please list ALL medications, including over the counter agents, vitamins and supplements, along with the DOSE and TIMES you take these items:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

4. Please list all previous surgeries, the dates of the surgery and the name of your surgeon to the best of your recollection:

☐Gallbladder_____ ☐Pancreas_____

☐Colon_____ ☐Esophagus or Stomach_____

☐Appendix_____ ☐Heart Surgery_____

☐Hysterectomy_____ ☐Hernia_____

Others:_____

_____

5. Allergies: Are you allergic to any medications: ☐NO ☐YES. Please list and describe what reaction you had:

_____

_____

Are you allergic to LATEX: ☐NO ☐YES

6. What is your social history:

Martial Status: ☐Married ☐Single ☐Divorced ☐Widow/Widower

Current occupation/employer:_____

Do you smoke?_____ How much?_____ How many years?_____

Did you smoke in the past?_____ For how long?_____

Do you drink alcohol?_____ How many drinks per day?_____ per week?_____

Do you use any illicit drugs?_____ If yes, what kind?_____

7. Family History: (please list age, if alive, and what if any diseases)

Mother_____ Father_____

Brothers/Sisters_____

Children_____

Any family history of Cancer, if yes whom:_____

8. Review of systems: Do you have signs or symptoms in any of the following areas? Please check the appropriate box.

Yes	No	Constitutional:
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Fatigue/weakness
☐	☐	Change of appetite
☐	☐	Fevers, Chills, Night Sweat

		Skin:
☐	☐	Rashes/Itching
☐	☐	Skin Cancer or other lesions

		Head:
☐	☐	Headaches
☐	☐	Dizziness / Lightheadedness
☐	☐	Seizures

		Eyes, Ears, Nose, and Throat:
☐	☐	Visual changes
☐	☐	Hearing changes / Ringing in your ears
☐	☐	Vertigo (Room feels like its spinning)
☐	☐	Sore Throat

		Respiratory:
☐	☐	Shortness of Breath
☐	☐	Cough or Sputum production
☐	☐	Coughing up Blood
☐	☐	Wheezing

		Cardiovascular:
☐	☐	Chest Pain
☐	☐	Short of breath with exertion
☐	☐	Pain in legs when walking
☐	☐	Swelling in legs
☐	☐	Palpitations (Heart feels like its fluttering)

		Genitourinary:
☐	☐	Urinary Frequency
☐	☐	Urgency, Hesitancy
☐	☐	Burning with urination (dysuria)
☐	☐	Getting up at night to urinate (nocturia)
☐	☐	Incontinence of urine
☐	☐	Date of Last Menstrual Period -_____

Yes	No	Gastrointestinal:
☐	☐	Abdominal pain
☐	☐	Difficulty swallowing (Dysphagia)
☐	☐	Heartburn
☐	☐	Nausea / Vomiting
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Vomiting Blood
☐	☐	Indigestion
☐	☐	Black tarry stools (Melena)
☐	☐	Hemorrhoids
☐	☐	Jaundice or Hepatitis
☐	☐	Fatty food intolerance
☐	☐	Anorexia – Lack of appetite

		Endocrine:
☐	☐	Temperature intolerance
☐	☐	Thyroid disease

		Musculoskeletal:
☐	☐	Arthalgias
☐	☐	Arthritis
☐	☐	Joint swelling / tenderness
☐	☐	Limited range of motion in joints
☐	☐	Back pain
☐	☐	History of Gout

		Hematologic/Lymphatic:
☐	☐	Anemia
☐	☐	Bleeding tendencies
☐	☐	Easy Bruising
☐	☐	Swollen lymph nodes

		Neurologic:
☐	☐	Passing out (syncope)
☐	☐	Weakness

		Psychiatric:
☐	☐	Anxiety
☐	☐	Depression

Please list any other complaints:_____

_____

MERCER GASTROENTEROLOGY, PC
2 Capital Way, Suite 487, PENNINGTON, NJ 08534
PHONE: (609) 818-1900
PATIENT REGISTRATION FORM

NAME: _____ AGE: ____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SECURITY #: _____

CITY: _____ TELEPHONE: HOME: _____

STATE: _____ ZIP: _____ WORK/ CELL: _____

MARITAL STATUS: _____ MALE: _____ FEMALE: _____

E-MAIL: _____

RACE: __Asian __Black __Hispanic __White
LANGUAGE SPOKEN: __English __Other __Sign __Spanish
ETHNICITY: __Latino __Non-Latino __Refuse to Respond

PRIMARY PHYSICIAN:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

PHARMACY INFORMATION:

NAME: _____

ADDRESS: _____

_____

PHONE: _____

MAIL ORDER RX: _____

LIST ALL YOUR OTHER PHYSICIANS:

_____

PRIMARY INSURANCE INFORMATION:

COMPANY: _____ SUBSCRIBER: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ ID #: _____

SECONDARY INSURANCE INFORMATION:

COMPANY: _____ SUBSCRIBER: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ ID #: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____ _____

SIGNATURE (PATIENT OR PATIENT REPRESENTATIVE) DATE

Commonly Asked Questions Regarding Your Privacy Rights

1. **Can my physician discuss my case with other providers and/or staff in the office?**
   Yes, as long as your physician is discussing only the information needed to accomplish a legitimate function (like treatment or payment for your treatment). This is called the "minimum necessary" standard under the Privacy Rule. Additionally, HIPAA does not require the physician to construct physical barriers to protect your information, but it does require your physician to use reasonable safeguards to protect your identity and confidential information in his/her office.

2. **Will the doctor's office still leave message reminders at my home?**
   Yes, unless you object to having the office contact you at home, such as with appointment reminders, your physician will continue to leave message reminders and communications with you as necessary to provide quality care.

3. **Can my physician still use a sign-in sheet and/or call my name in the waiting room to announce my "turn"?**
   Yes, your physician may still have you sign your name at the time of registration or announce your name in order to call you to an exam room.

4. **Can my physician still fax records?**
   Yes, your physician may fax your health information as long as reasonable safeguards are used (like verifying the correct fax number).

5. **Do the HIPPA requirements apply to non-physician staff such as nurses, medical students and residents walking in the hallways or in the exam rooms?**
   Yes, clinical staff, students and trainees must follow the HIPAA Privacy Rules.

6. **Can my physician discuss my care with a close family member or friend as we have been doing in the past?**
   YES _____ **NO** _____ **If so, Who?** _____
   Yes, HIPPA allows your physician to disclose your health information to family members and friends involved in your care as long as you do not object to the disclosure.

7. **Does HIPAA still allow parents the right to access their children's records?**
   Parents of children 17 years and under generally have access to their child's health information. However, HIPAA usually defers to state law in recognizing certain confidential relationships between a minor and their physician in specific treatment situations.

8. **If my physician is referring me to a specialist, can this specialist have access to my record before I enter his/her office for the first time?**
   Yes, HIPAA does not prohibit the specialist from accessing your health information to prepare the process for seeing you for the first time. However, as the case is now, you may need to authorize disclosure of your records to the specialist.

9. **Does HIPAA prevent physician offices from reporting patients to collection agencies?**
   No. Under HIPAA, collection activities are considered legitimate payment functions, and disclosures of "minimum necessary" data to collection or credit agencies to receive payment are possible.

10. **Does HIPAA allow my physician to share my health information to market goods and services?**
    HIPAA prohibits the selling or disclosing of your private health information, including demographics used in registration, to third parties for marketing purposes without your specific authorization.

SIGNATURE:_____ **DATE:**_____

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize MERCER GASTROENTEROLOGY to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, MERCER GASTROENTEROLGY can refuse to treat me.

I have received a copy of the Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand that I may revoke this consent at any time by notifying MERCER GASTROENTEROLOGY in writing, but if I revoke my consent, such revocation will not affect any actions that MERCER GASTROENTEROLOGY took before receiving my revocation.

I understand that MERCER GASTROENTEROLOGY has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that MERCER GASTROENTEROLOGY restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that MERCER GASTROENTEROLOGY does not have to agree to such restrictions, but that once such restrictions are agreed to, MERCER GASTROENTEROLOGY must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative (Form MUST be completed before signing.)

Date

_____

Printed name of patient or patient's representative and relationship to patient.

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call Mercer Gastroenterology promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 609-818-1900. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the your medical record as a "no-show".

- Missed office visit appointment: $50.00 fee will be billed to your account
- Missed procedure appointment: $100.00 fee will be billed to your account
- Third missed appointment or procedure: $100.00 fee will be billed to your account and you may be discharged from our practice

Please sign

_____

Please print name

_____

Please date

_____