516-248-2422

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Locations in Nassau, Suffolk and Queens

ESTABLISHED PATIENTS

Name:____ Date:_____________

Date of Birth_______________

E-mail address:___________________________
Please check here if you don't have an email address or don't wish to disclose it.________

Profession:___________________________________

Current height:__________ Current weight:__________

Reason for today's visit:____

Since last visit symptoms have (please check)
_____worsened _____improved
_____stayed the same _____completely resolved

Please list all medications you are currently taking, including over-the counter:

____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________
____________________ ____________________ ____________________ ____________________

Have there been any changes since your last visit? If not, please circle "No change". If so, please list.

Medical history?	No change	____
Allergies?	No change	____
Surgeries?	No change	____
Family history?	No change	____
Smoking or alcohol?	No change	____

Does your insurance require a referral? Yes No
Do you have a referral today? Yes No

Has there been any change in your medical insurance since last visit? Yes No
If so, please provide us with your current insurance information.
____

-YOUR COPAY IS EXPECTED TO BE PAID AT EACH VISIT-Thank you!

Patient signature:____

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INFORMED CONSENT FOR ANORECTAL PROCEDURES

You may undergo anoscopy or proctosigmoidoscopy as part of your rectal examination. These tests allow your doctor to look at the inner lining of your anus, rectum and the lower part of the colon. These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions (such as diverticulosis).

You may be treated for one or more of the following conditions:
- Hemorrhoids
- Anorectal lesions
- Anal fissure
- Perirectal abscess

Nature and purpose of proposed treatment:
- Removal of painful and /or bleeding hemorrhoidal tissue; treatment of internal hemorrhoids with injection sclerotherapy, rubber band ligation and/or infrared coagulation
- Treatment of infection in perirectal area, with drainage and collection of any pus
- Treatment of anal fissure
- Removal of anorectal lesions

Risks common to all surgical procedures:
- Injury to a blood vessel or excessive bleeding
- Infection, which may require the use of antibiotics. In rare cases, another procedure may be necessary to remove the infection

Risks and possible complications of the proposed treatment:
- Pain after procedure, which may require the use of pain medication
- Bleeding
- Infection that may require the use of antibiotics. In rare cases, another procedure may be necessary
- Recurrence which may require another surgical procedure

I acknowledge and understand that prior to any procedure being performed, more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained. I understand the above information and give my consent to have the described treatment performed.

______________________	______________________	__________
Print Name	Patient Signature	Date

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PATIENT REGISTRATION

Who are you seeing today? Dr. Dean Pappas/Dr. Frank Caliendo/Dr. Steven Pelaez/Dr. Mala Balakumar/ Dr. Cesar Sanz/Grace Halleran, PA

Last Name:________________________________ First:_________________________________ MI:_____

Address:________________________________ City:_______________________State:______ Zip:_______

Home #:______-_______-_______Cell#______-_______-_______Social Security#:_______-_______-_______

Place of Employment:______________________________________ Work #:________-________-________

What is your Date of Birth:_________/_________/_________ Age:_________

Circle One: Male/Female Marital Status: Single/Married/Divorced/Separated/Widowed

What is your E-mail Address?

___________________________________@_________________________

Please check here if you don't have an e-mail address or don't want to disclose it.__________

Who is your Family or Primary Care Physician?

Name:____

Address:_______________________________________

Phone#:______-______-______ Fax#:_____-_____-_____

Who may we thank for this referral?
Doctor/Friend/Family/Insurance Company/Internet/Other

If a Physician referred you, Who is the referring Physician:

Name:_____________________________________ Phone#:______-______-______

Address:____

Emergency Contact Information:

Name:____Phone#:______-______-______

Address:____

What is your relationship to the above person?____________________________________

Name:_____________________________________

Insurance Information

Does your insurance require a referral? Yes No
Do you have a referral today? Yes No

Primary Insurance Company:______________________________Policy#:_________________________

If insurance is under your spouse/parent for billing purposes, please provide:

Name:______________________________Date of Birth:_____/_____/_____SS#:_____/_____/_____

Secondary Insurance Co. Name:____________________________Policy#:_________________________

If under spouse/parent:_________________Date of Birth:_____/_____/_____SS#:_____/_____/_____

Third Insurance Co. Name:_______________________________Policy#:__________________________

If under spouse/parent:_________________Date of Birth:_____/_____/_____SS#:_____/_____/_____

What is your Pharmacy Information?

Name:____Phone#:_____-_____-_____

Address:____

MEANINGFUL USE REQUIREMENT(government mandated)

Please Circle One:

Race: White, Hispanic, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic/Non-Hispanic Preferred Language:_________________

Social History –Please check ALL that apply:

Smoking Status: ( ) Never ( ) Former – When did you quit:_________________
( )Current daily smoker – How many packs:_________________
( )Current sometimes smoker- Explain:_____________________

Privacy Practices Acknowledgement:

I have Read/Received the notice of privacy practice and I have been provided an opportunity to review it. Due to the HIPPA Law, we are Not Allowed by Law to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

INSURANCE ASSIGNMENT AND RELEASE:

I authorize the release of medical information necessary to process this claim and also authorize of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours . By law, we must collect your carrier designated copay, deductible and co-insurance. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a $10 charge will be added to your account. If there are reasons you cannot make your copay at each visit, arrangements MUST be made and approved in advance. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature:____Date:_____/_____/_____