Peter H. Rubin, MD

920 Park Avenue
New York, NY 10028
(212) 535-3400
parkgastro.com

New Patient Questionnaire

Demographic Information

Name: _____ Gender: _____

Date of Birth: _____ Age:_____ Social Security #: _____

Home Address: _____ City:_____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail [*Please print clearly*]:_____

Emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Clinical Information

Primary Care Doctor: Name: _____

Address: _____

Phone: _____

Referring Doctor: Name: _____

Address: _____

Phone: _____

Preferred Pharmacy: *NY State Law mandates e-prescribing most medications. Please provide detailed pharmacy information.*

Name: _____

Address: _____ ZIP code: _____

Phone: _____

Health Insurance: *Please provide copies of your most recent active insurance cards.*

Signature & Agreement

"I verify that the information I provided is accurate and correct to the best of my knowledge."

Printed Name: _____ (patient or representative)

Signature: _____ Date: _____

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HIPPA Privacy Notice

Dr. Rubin, his associates and their staff understand that your medical information is private and confidential. We are required by law to maintain privacy of your "protected health information". The complete notice of privacy practices is found in our office and we require you to review the entire notice and acknowledge receipt and understanding of the information. This is a summary of how medical information about you may be used.

Your medical information may be used or disclosed for the following reasons:

- Medical treatment including provision, coordination or management of your health care, including consultations between health care providers.
- Performing health care operations including quality assurance activities, case management, responding to patient comments, and administrative activities.
- Processing payment for services rendered including activities undertaken to obtain reimbursement for healthcare provided to you, billing, collections, claims management, determination of eligibility and coverage.

Ancillary Medical Services

In the course of your care your doctor may deem it necessary to refer you for studies not performed directly in our office. This includes laboratory tests, radiology studies and pathology evaluation. You may also be referred to other physicians/specialists. These facilities and physicians will have separate charges for services rendered. It is your responsibility verifying that these facilities/physicians participate in your insurance network. If a bill is received from such a facility/physician, you will need to contact them directly to provide them with any necessary insurance information and address any charges. If there are specific laboratories or radiology offices that you prefer or your insurance mandates you use it is your responsibility to inform us so that the appropriate arrangements can be made. The following is a non-comprehensive list of facilities commonly used by our physicians:

Laboratories:

- Sunrise Laboratories 800-782-0282
- Quest Diagnostics 866-697-8378
- LabCorp 866-697-8378

Radiology & Endoscopy Offices:

- New York Medical Imaging 212-535-9770
- Mount Sinai Radiology 212-241-8333

Pathology Laboratories:

- Mount Sinai Pathology 212-241-8014
- CBL Path 877-225-7284
- Endochoice 888-272-1001

Anesthesiology Services:

- Dr. John Grillo 212-535-3400
- Mount Sinai Anesthesiology 212-241-7473

Patient Financial Notice Agreement & Responsibilities

Our doctors' insurance participation varies and they do not participate in all insurance plans. In addition, health insurance coverage varies and you are responsible for reading and understanding your specific policy with regards to referrals, deductibles and co-payments as outlined in your insurance contract. If a referral from your doctor is required, it is your responsibility to obtain it from your referring physician prior to your appointment.

Complete and accurate insurance information, including presentation of your insurance card, must be provided at time of your visit. Failure to present accurate insurance information may result in a denial of benefits from your insurance carrier. In this event, you are responsible for payment for the services rendered. You are responsible for

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co-payment, payable at the time of visit, and any deductible or percentage of the billed service considered the patient's responsibility by the insurance company after payment of that service has been issued to the physician.

We will make efforts to obtain pre-certification for procedures and studies you may need. However this does not guarantee full coverage for the services by your insurance company. In addition, certain tests and procedures that our doctors feel are important for your health may not be reimbursed in full by your insurance. If your insurance denies payment you are responsible for the full payment for the care you receive.

No-Show Policy

If you are unable to make it to a scheduled appointment we ask that you inform the office at least 2 business days in advance. This will allow us provide the time slot to another patient who may need medical care. We reserve the right to bill a $50.00 no-show fee for missed appointment without adequate notice.

Signature & Agreement

"I acknowledge receipt and understanding of privacy practices for protected health information."

"I understand my responsibilities as outlined in this agreement. I agree to pay in full any outstanding balance."

Printed Name: _____ (patient or representative)

Signature: _____ Date: _____

Credit Card Authorization

- If your insurance is not in effect on the date of service, you have not met your deductible in full, or your insurance company refuses to pay for the care you receive, you are responsible for paying the outstanding balance in full within 10 days of receipt an invoice.
- Any insurance payments sent directly to you for services rendered by our physicians must be forwarded in full to our practice within 10 days of receipt of an invoice.
- In the event that you do not pay for services rendered in a timely fashion we ask for your permission to charge the credit card listed below for the full owed amount. You will be notified in advance prior to any charges.

Credit Card Authorization

"I authorize the use of my credit card to pay for any outstanding balance for services rendered."

Card Type: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Cardholder's name: _____ Card exp date: _____

Card number: _____ Security code: _____

Signature: _____

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Name: _____ **Date of Birth:** _____

Please provide the information below to the best of your ability. Your answers will help your doctors better understand your medical concerns and conditions. If you are uncomfortable with any question or do not remember the information, leave it blank. All questions are **optional** and will be kept strictly **confidential**.

Reason for your visit

What is the main reason for your visit? _____

_____

Past Medical History

Have you ever had the following GI disorders, symptoms or procedures?

☐ Acid reflux	☐ Chronic constipation	☐ Chronic diarrhea	☐ Hemorrhoids
☐ Rectal bleeding	☐ Black stool	☐ Vomiting blood	☐ Diverticulitis
☐ Excessive bloating	☐ Chronic abdominal pain	☐ Ulcer disease	☐ Trouble swallowing
☐ Liver disease	☐ Pancreas disease	☐ Gallbladder disease	☐ Colon cancer
☐ Irritable bowel syndrome (IBS)		☐ Crohn's disease	☐ Ulcerative colitis

☐ Colonoscopy; when/findings: _____

☐ Endoscopy; when/findings: _____

☐ Capsule endoscopy; when/findings: _____

Please list any **medical conditions and surgeries** you have now or have had in the past:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Medications & Allergies

Please list any **allergies** to medications that you have now or have had in the past:

_____ _____

_____ _____

Please list any **prescription medications** that you take:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any **over-the-counter medications, vitamins or supplements** that you take:

_____ _____

_____ _____

Social & Family History

Tobacco: ☐ Never ☐ Former; Quit date _____ ☐ Current; How much? _____

Alcohol: ☐ None ☐ Yes, please specify: _____

Drugs: ☐ None ☐ Yes, please specify: _____

Marital status: _____

Are you sexually active? ☐ No ☐ Yes

Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ High-level

Occupation: _____

Are there any medical conditions that run in your family?

☐ Heart disease ☐ Diabetes ☐ Liver disease ☐ Kidney disease ☐ Psychiatric illness ☐ Bleeding/clotting disorders

☐ Inflammatory bowel disease: _____

☐ Colon cancer: _____

☐ Stomach cancer: _____

☐ Other cancers: _____

☐ Other conditions: _____

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Preventative Health Care

Have you had screening for the following preventable medical conditions?

☐ Colon cancer? Please specify: _____

☐ Breast cancer? Please specify: _____

☐ Cervical cancer? Please specify: _____

☐ Prostate cancer? Please specify: _____

☐ Osteoporosis? Please specify: _____

Review of Systems: Please check all that apply

Constitutional
☐ Exercise intolerance
☐ Fatigue
☐ Fever
☐ Change in appetite
☐ Weight gain (_____lbs)
☐ Weight goss (_____lbs)

Allergic/Immunologic
☐ Frequent sneezing
☐ Hives/itching
☐ Runny nose
☐ Sinus pressure
☐ Frequent infections

Eyes
☐ Dry eyes, irritation
☐ Vision change
☐ Red eyes

Ears/Nose/Mouth/Throat
☐ Difficulty hearing
☐ Dry mouth
☐ Ear pain
☐ Frequent nosebleeds
☐ Hoarseness
☐ Mouth ulcers
☐ Nose/sinus problems
☐ Ringing in ears

Gastrointestinal
☐ Please note above

Endocrine
☐ Increased thirst/hunger
☐ Heat/cold intolerance

Cardiovascular
☐ Chest pain
☐ Chest heaviness/pressure
☐ Irregular heart beat
☐ Shortness of breath when lying down
☐ Shortness of breath when walking
☐ Leg swelling
☐ Calf pain when walking

Respiratory
☐ Cough
☐ Coughing up blood
☐ Shortness of breath
☐ Sleep apnea
☐ Snoring
☐ Wheezing

Genitourinary
☐ Blood in urine
☐ Difficulty urinating
☐ Incomplete bladder emptying
☐ Increased urinary frequency
☐ Urinary incontinence

Hematologic/Lymphatic
☐ Easy bruising/bleeding
☐ Swollen glands

Skin
☐ New/changing moles
☐ Dry skin
☐ Eczema
☐ Itching/Rash
☐ Yellowing of skin/eyes

Musculoskeletal
☐ Back pain
☐ Joint pain
☐ Muscle aches
☐ Muscle weakness

Neurological
☐ Dizziness/fainting
☐ Headaches/migraines
☐ Memory loss
☐ Numbness
☐ Seizures

Psychiatric
☐ Alcohol dependence
☐ Drug abuse
☐ Anxiety
☐ Depression
☐ Feeling unsafe at home
☐ Sleep problems

Breast
☐ Lumps
☐ Pain
☐ Discharge