**Name:** _____

Last First Middle Nickname

**Date of Birth:** _____ Sex:_____

**Primary Address:** _____

**Billing Address:** _____

**Home Number :** _____ **Cell Phone Number :** _____

**Email Address:** _____

**Pharmacy: (Name & Number)** _____

**Employer/School:** _____

**Emergency Contact** _____**Phone#**_____ **Relationship:**_____

**Primary Care Doctor:(Name & Number)** _____

**Referring Doctor: (Name &Number)** _____

**Primary Insurance:**

Insurance Name: _____

Member ID: _____

Subscriber Name:_____

DOB: _____ Relationship: _____

**Secondary Insurance:**

Insurance Name: _____

Member ID: _____

Subscriber Name: _____

DOB:_____ Relationship: _____

| Name: | DOB: | Reason for visit: |
|---|---|---|

**Have you had a screening colonoscopy?** ☐ Yes ☐ No If yes, **when?**_____

**Please check any persistent or recurring symptoms you have:** ☐ **I am having no symptoms**

| **Gastrointestinal**: | **General**: | **Neurological**: | **Skin**: | **Genitourinary**: |
|---|---|---|---|---|
| ☐Abdominal pain | ☐Dizziness | ☐Confusion | ☐Itching | ☐Painful urination |
| ☐Constipation | ☐Fatigue | ☐Seizures | ☐Rash | ☐Frequent urination |
| ☐Diarrhea | ☐Fever | ☐Severe headache | ☐Breast lumps | ☐Trouble urinating |
| ☐Difficulty swallowing | ☐Heat intolerance | **Cardiovascular**: | ☐Jaundice/yellow skin | **Musculoskeletal**: |
| ☐Heartburn/Reflux | ☐Cold intolerance | ☐Chest pain | **ENT**: | ☐Joint pain |
| ☐Nausea | ☐Weight loss | ☐Irregular heartbeat | ☐Cough | ☐Muscle pain |
| ☐Rectal bleeding | ☐Weight gain | **Psychiatric**: | ☐Heard of hearing | **Respiratory**: |
| ☐Vomiting | **Hematologic**: | ☐Depression | ☐Hoarseness | ☐Sleep apnea |
| | ☐Anemia | ☐Anxiety | ☐Vision changes | ☐Shortness of breath |
| | ☐Bleeding tendency | ☐Panic attacks | | |

**Social history**: **Tattoos?** ☐ Yes ☐ No Piercings? ☐Yes ☐ No

| | | | | | |
|---|---|---|---|---|---|
| **Tobacco use:** ☐ Never | ☐ Former | ☐Current – everyday | ☐Current – some days | **Type:** _____ |
| **Alcohol use:** ☐ Never | ☐ Former | ☐Current – everyday | ☐Current – some days | **Type:** _____ |
| **Caffeine use:** ☐ Never | ☐ Former | ☐Current – everyday | ☐Current – some days | **Type:** _____ |
| **IV drug use:** ☐ Never | ☐ Former | ☐Current – everyday | ☐Current – some days | **Type:** _____ |

**Recent ER visit?** ☐ Yes ☐ No **Date:** _____ **Fallen in the last year?** ☐ Yes ☐ No **Date:** _____

**Any of the following vaccinations?** ☐Hepatitis A ☐ Hepatitis B

| **Surgical history:** | | **Medical history:** | |
|---|---|---|---|
| ☐Colon surgery | ☐Small intestine surgery | ☐High blood pressure | ☐Anemia |
| ☐Hemorrhoid surgery | ☐Appendectomy | ☐Coronary artery disease | ☐Colon polyps |
| ☐Gallbladder surgery | ☐Breast surgery | ☐Heart stent | ☐Diverticulitis |
| ☐Gastric surgery | ☐C—section | ☐Pacemaker | ☐Ulcerative colitis |
| ☐Liver surgery | ☐CABG/Heart surgery | ☐Defibrillator | ☐Crohn's disease |
| ☐Hysterectomy surgery | ☐Hernia surgery | ☐Atrial fibrillation(AFIB) | ☐Reflux |
| ☐Laparotomy | ☐Prostate surgery | ☐COPD | ☐Stomach ulcers |
| ☐Obesity surgery | ☐Spinal surgery | ☐Diabetes | ☐Cirrhosis |
| ☐Thyroidectomy | ☐Tubal Ligation | ☐Seizures | ☐H. pylori |
| ☐Tonsillectomy | ☐Valve replacement surgery | ☐Sleep apnea | ☐Celiac disease |
| ☐Transplant surgery | ☐Other: _____ | ☐Kidney disease | ☐Fatty liver |
| | | ☐Blood transfusion | ☐EoE |
| | | ☐Hepatitis B | ☐Pancreatitis |
| | | ☐Hepatitis C (HCV) | ☐Gallstones |
| | | ☐Gastroparesis | ☐Other: |

| **Family history**: | | **Allergies:** | |
|---|---|---|---|
| Relationship | Relationship | ☐No known allergies | ☐Penicillin |
| ☐Colon cancer _____ | ☐Pancreas cancer _____ | ☐Codeine sulfate | ☐Sulfa |
| ☐Stomach cancer _____ | ☐Breast cancer _____ | ☐Versed | ☐Demerol |
| ☐Esophagus cancer _____ | ☐Prostate cancer _____ | ☐Morphine | ☐Latex |
| ☐Colon polyps _____ | ☐Other | ☐Iodinated contrast | ☐Adhesive tape |
| | | ☐Fentanyl Citrate | ☐Other: |
| | | ☐Propofol | |

**Medications**: List current medications (including herbal and OTC) and dosage OR attach list

| Name of drug | Strength/frequency | Name of drug | Strength/frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# Benefit Assignment/Release Of Information

I assign all medical and/or surgical benefits from medicare, private Insurance Carrier(s), and any other health plan coverage to which i am entitled to Chris Demetriou MD P.C., to receive payment for their services. A photocopy or facsimile of this assignment is to be considered as valid as the original. I authorize Chris Demetriou MD P.C. to release all information necessary, including medical records, to secure such payment. I certify that the information given by me in applying for payment is correct. I understand that I am financially responsible for any balance not covered by my insurance.

**Patient signature:** **Date:**

# Patient Hipaa Consent Form

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patients rights section describing your rights under law, you may have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**The patient understands that:**

1) Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2) The practice has a notice of privacy practices and that the patients have the opportunity to review this notice.
3) The patient may revoke this consent in writing at any time and all future disclosures will then cease.
4) I understand that at times i may be notified of test results by phone.

**Check all that apply**

- ☐ I allow my doctor's office to leave messages on my home or cell phone.
- ☐ I allow my doctor's office to leave a message with the following specified family members (please list names and numbers)

**Patient Signature** **Date:**

Chris Demetriou M.D. PC 623 Stewart Ave Ste 106 Garden City, Ny 11530

Dear Patient,

Thank you for choosing our practice for your medical needs. Please take a moment to review our financial policy. We render services which are medically necessary, however some insurers have policies that may not reimburse for such services. We will assist you with any claims as best we can, but ultimately you are responsible for services rendered not covered by your policy.

AUTHORIZATION TO PAY: I authorize payment of medical benefits to be made on my behalf to **Chris Demetriou, M.D. PC** for any services rendered.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize any holder of medical information, regarding me, to release said information to my insurance company and its agents.

INSURANCE RESPONSIBILITY: **Chris Demetriou M.D. PC** has informed me that I am responsible for providing the office with accurate insurance information and obtaining any referrals needed from my Primary Care Physician.

MEDICARE/MEDICAID PATIENTS: **Chris Demetriou M.D. PC** has also informed me that he is NOT a participating provider with ANY Medicaid insurance policies. Any expenses incurred under Medicaid will be the responsibility of the patient. This also applies to Medicare patients with Medicaid as a secondary coverage.

I permit a copy of this authorization to be used in place of the original. This authorization will remain in force until termination is requested in writing by the enrollee.

I understand that payment is due when services are rendered unless prior arrangements are made. **Chris Demetriou M.D. PC** will act as an agent in helping me obtain reimbursement from my insurance company. I understand that I am financially responsible for any copayments, coinsurances, deductible, non covered services etc stated by my insurance plan.

I understand that there is a no show fee of 75.00 for any appointments missed or cancelled without 24 hours notice. Any no show fee charged will be the responsibility of the patient personally.

Patient printed name_____

Patient Signature _____

Date _____