

CONSULTANTS IN GASTROENTEROLOGY, INC.

JOEL S. SPELLUN, M.D. • JAY A. SORGMAN, M.D. • PHILIP A. MCANDREW, M.D.
ANDREW D. STONE, M.D. • BRET A. ANCOWITZ, M.D. • BARBARA C. RAMPO, RNP

148 West River Street
Providence, RI 02904

TEL: (401) 421-6306
FAX: (401) 453-0330

1524 Atwood Avenue
Johnston, RI 02919

To Our New Patients

Welcome to our office. In order to expedite your visit, **please complete the attached forms and bring them with you when you come for your appointment.. You must also bring your insurance card.**

If your insurance requires a referral, please notify your Primary Care Physician. Your doctor's referral must be faxed to our office by the time you come in for your appointment. Our fax number is (401) 453-0330.

****** Please note that this first visit includes a physical exam which may require you to get undressed. ******

If you have had any recent labs or testing, please bring them with you.

Your appointment is scheduled on _____ at _____.

We are looking forward to meeting you and thank you in advance for your cooperation.

DIRECTIONS TO 148 WEST RIVER STREET PROVIDENCE

RT. 95 NORTHBOUND:

TAKE EXIT 24 (BRANCH AVE.) AT STOP SIGN TAKE A LEFT. PROCEED TO FIRST TRAFFIC LIGHT. AT LIGHT (STOP AND SHOP) TAKE A LEFT ONTO WEST RIVER STREET. GO TO STOP SIGN AND BEAR RIGHT, THEN FIRST RIGHT INTO NORTH ENTRANCE PARKING LOT. SUITE #3.

RT. 95 SOUTHBOUND:

TAKE EXIT 24 (BRANCH AVE.) AT STOP SIGN TAKE A RIGHT. AT LIGHT (STOP AND SHOP) TAKE A LEFT ONTO WEST RIVER STREET. GO TO STOP SIGN AND BEAR RIGHT, THEN FIRST RIGHT INTO NORTH ENTRANCE PARKING LOT. SUITE #3.

DIRECTIONS TO THE JOHNSTON OFFICE

ROUTE 6 WEST ATWOOD AVE. EXIT, RIGHT ONTO ATWOOD AVE., STRAIGHT TO 1524 ATWOOD AVE.

ROUTE 295 NORTH TAKE EXIT 6A (RTE. 6 EAST) FOLLOW TO ATWOOD AVE. (1ST EXIT), LEFT ONTO ATWOOD AVE., STRAIGHT TO 1524 ATWOOD AVE.

ROUTE 295 SOUTH TAKE EXIT 6A (RTE. 6 EAST) FOLLOW TO ATWOOD AVE. (1ST EXIT), LEFT ONTO ATWOOD AVE., STRAIGHT TO 1524 ATWOOD AVE.

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PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY#: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK or CELL PHONE: _____

SEX: M ____ F ____ DATE OF BIRTH: _____ AGE: _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF PARENT or SPOUSE: _____

PHARMACY: _____ PHARMACY PHONE: _____

PRIMARY CARE PHYSICIAN: _____

REFERRED BY: _____

EMERGENCY NOTIFICATION

NAME: _____ TELEPHONE: _____

HEALTH INSURANCE

PRIMARY INSURANCE PLAN NAME: _____

INSURANCE ID #: _____

EMPLOYEE SPONSORED PLAN: YES: ____ NO: ____ EMPLOYEE NAME: _____

SECONDARY INS: _____ ID #: _____

ASSIGNMENT OF BENEFITS: I hereby assign payment of authorized Medicare benefits and/or any other medical and/or surgical benefits, to include Major medical benefits to which I am entitled, to be made on my behalf to CONSULTANTS IN GASTROENTEROLOGY, INC. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE: _____ DATE: _____

SIGNATURE OF _____ DATE: _____

RESPONSIBLE PARTY (if minor):

NAME _____ DATE _____

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GENERAL MEDICAL HISTORY

MEDICAL PROBLEMS: _____

PRODUCTIVE COUGH: _____ **NIGHT SWEATS:** _____ **COUGHING UP BLOOD:** _____

PREVIOUS SURGERY: _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

ANY HISTORY OF BLEEDING OR CLOTTING PROBLEMS? _____

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE DENTAL WORK? _____

FAMILY HISTORY:

PLEASE LIST ANY MEDICAL PROBLEMS IN FAMILY MEMBERS. (IF DECEASED, PLEASE LIST AGE AT TIME OF DEATH AND CAUSE)

FATHER: _____

MOTHER: _____

BROTHERS: _____

SISTERS : _____

CHILDREN: _____

REASON FOR TODAYS VISIT: _____

Consultants in Gastroenterology
Ocean State Endoscopy
Privacy Consent Form

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

Yes / No (please circle one)

I give my permission for telephone messages to be left on my answering machine re: upcoming appointments, procedures, test results or health insurance.

Yes / No (please circle one)

I give my permission for the above information to be disclosed to the following individuals. (ex: spouse, family members, etc.)

Please list name and relationship

If this list should change, please contact our office

Signature

Date

Print Name