PATIENT INFORMATION SHEET

(Please Print) Date: _____

Primary/Referring Physician _____ Phone# _____

Patient Name: _____ Date of birth _____

Social Security Number _____

Responsible party _____ Relationship to patient _____

Social Security Number _____ Race _____ Ethnicity _____

☐ single ☐ married ☐ widowed ☐ divorced ☐ separated ☐ Male ☐ Female

Home address _____ City _____ St _____ Zip _____

Home tel # _____ Work tel # _____

Name of employer _____ Address _____

City _____ St _____ Zip _____ Occupation _____

Spouses full name _____ DOB _____ SS# _____

Address if different from above _____

Home tel # if different from above _____ Email address _____

Spouses employer _____ Work tel # _____

Address _____ St _____ Zip _____

Do you have insurance? ☐ yes ☐ no Insurance company _____

Address _____ ID number _____

Any other insurance? ☐ yes ☐ no Insurance company _____

Address _____ ID number _____

Known allergies _____

Are there any cultural, religious, or language barriers that you have that may affect your medical care? ☐ Yes ☐ No Explain _____

_____

_____

Whom may we contact in case of emergency? _____

I will be paying today by: ☐ cash ☐ check ☐ credit card

Can diagnostic test results be given to a family member? ☐ YES ☐ NO Name _____

Preferred Language _____

Gastromed Healthcare, PA
25 Monroe Street
Bridgewater, NJ 08807

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Gastromed Healthcare, P.A. Bridgewater .
For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Gastromed Healthcare, P.A. I understand that diagnosis or treatment of me by Dr.Jeffrey Unger, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Gastromed Healthcare, P.A. is not required to agree to the restrictions that I may request. However, if Gastromed Healthcare, P.A. Bridgewater agrees to a restriction that I request, the restriction is binding on Gastromed Healthcare, P.A. and Dr. Jeffrey Unger, MD

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Jeffrey Unger, MD or Gastromed Healthcare, P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Gastromed Healthcare, P.A. Notice of Privacy Practices prior to signing this document. The Gastromed Healthcare, P.A. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Gastromed Healthcare, P.A. This Notice of Privacy Practices also describes my rights and Gastromed Healthcare, P.A. duties with respect to my protected health information.

Gastromed Healthcare, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Gastromed Healthcare, P.A. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.