DEPARTMENT OF MEDICINE

Gastroenterology and Hepatology Division

Welcome to our Practice!

Enclosed please find our New Patient Forms.

MEDICINE

MEDICINE of THE HIGHEST ORDER

Please complete the New Patient Questionnaire attached
to the best of your abilities and bring it with you to your appointment.

With: on: Time:

We have multiple sites; please report to the marked location.

D Gastroenterology & Hepatology Division D Gastroenterology & Hepatology Division
180 Sawgrass Dr. 601 Elmwood Ave
Suite 230 Silver Elevators to the 4th Floor
Rochester, NY 14620 Rochester, NY 14642
(585) 275-4711 (585) 275-4711

Important information about insurance:

Not all insurances cover all visits/procedures. It is important that you check with your insurance carrier prior to your appointment to ensure that your visit/procedure will be covered. Please note that you will be financially responsible for any unpaid balances. When you arrive for your appointment, you may be asked to sign a Waiver Agreement or an Advance Beneficiary Notice (ABN). Signing this form means you are responsible for any costs of services provided which are not covered by your insurance carrier. Your copay is due at the time of service. Please call the number listed on your insurance card if you have additional questions about coverage.

When checking in for your appointment:

As of August 1, 2009, we are asking all patients to show photo ID when checking in for their appointments in order to comply with new federal regulations designed to protect patients from identity theft. Medical identity theft is a growing problem across the United States with over 250,000 cases each year. We greatly appreciate your cooperation and thank you for partnering with us to assure that we provide you and your loved ones with exceptional care. Ifyou have any concerns about this policy, please call the Integrity Hotline at (585) 756-8888.

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www.gastro.urmc.edu • gastro hep@urmc.rochester.edu e-mail

[g] Outpatient STRONG MEMORIAL HOSPITAL
DIGESTIVE DISEASE UNIT
PATIENT QUESTIONNAIRE
SMH 1334 MR

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Please fill out all items in this form as completely as possible.

Name:--------------------------- Date of Visit: _________ Gender: Male Female

Referring Care Provider:---------------- Primary Care Provider (if different):---------------

Briefly explain the reason you were referred to the Gastroenterologist: ----------------------------

Have you seen another Gastroenterologist in the past? D Yes D No If yes, advise name(s): -------------------

Please answer the following questions:
OYes 0No 1. Have you had a recent change in your appetite?
OYes 0No 2. Do you have difficulty swallowing food or liquids?
OYes 0No 3. Does indigestion or

STRONG MEMORIAL HOSPITAL

DIGESTIVE DISEASE UNIT
PATIENT QUESTIONNAIRE

SMH 1334 MR
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Current Medications (including prescription medications and over-the-counter drugs such as aspirin, vitamins and herbs}: Medication Name Dose How Often Reason for taking it
1.
2.
3.
4.
5.
6.
7.
8.
9.

10.~-~~~~~~~~~~~~

Are you being treated for any health problems associated with the areas listed below? YES NO Specify
D D Recent fever, chills, sweats or weakness
D D Seizures, stroke, or other neurologic disease
D D Vision, or hearing problems
D D Hypertension or heart attack
D D Chest pain, palpitations, valve disease, or murmur
D D