NJ GASTRO
A DIGESTIVE WELLNESS CENTER
973-645-0000

24 MERCHANT ST. NEWARK, NJ 07105
WWW.NJGASTROENTEROLOGY.COM
@njgastrollc

PATIENTS INFORMATION			
Name:			**Birth Date:**
Sex: ☐Male ☐Female ☐ Other ☐_____		**Email:**	
Address:	**City:**	**State:**	**Zip Code:**
Cell #	**Home #**	**Work #**	
Cellphone Type: ☐iPhone ☐Android ☐Non-Smartphone ☐Other		**Social Security #**	
Marital Status: ☐Single ☐Married ☐Engaged ☐Divorced ☐Separated ☐Widow ☐Other _____			
Referred by:☐Doctor☐Insurance☐Family/Friend☐Our Website☐Internet/Google☐Facebook/Instagram☐_____			

PRIMARY CARE DOCTOR	PHARMACY
Doctor's Name:	**Pharmacy's Name:**
Phone:	**Phone:**
Address:	**Address:**

EMERGENCY CONTACT	
Name:	**Relationship:**
Home #	**Cell #**

HIPPA	
Please list the relatives or friends, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment, health care operations, etc.)	
Name:	**Name:**
Relationship:	**Relationship:**
Phone #	**Phone #**

INSURANCE INFORMATION			
Primary Insurance:		**Secondary Insurance:**	
Member ID #		**Member ID #**	
Name of Insured:		**Name of Insured:**	
Relationship:	**Date of Birth: / /**	**Relationship:**	**Date of Birth: / /**

1) I, the undersigned, authorize and direct NJ Gastro, LLC staff members to provide any treatments deemed necessary, whether in person or virtually through telemedicine. I have read and understand this patient history form and certify that all information is correct. I hereby accept responsibility for any amount not paid by my insurance.
2) I hereby authorize NJ Gastro, LLC to release my medical information to the listed above
3) I have been informed that Dr. Barritta and Dr. Weiss have ownership interest in the Ironbound Endo-Surgical Center.
4) I have read and understand the information provided to me by NJ Gastro, LLC regarding the Patient's bill of rights and responsibilities.
5) I understand and agree that if I fail to make any of the payments in a timely manner, I will be responsible for all costs of collecting monies owed to Ironbound Endo Surgical Center, P.C, NJ Gastro LLC, including collection fees, court costs and attorney's fees. The collection fee of 40% shall be due 30 days after the time that payment is due. If a payment is not made within 60 days from the time of the service, the credit card on file will be charged.

SIGNATURE _____ **DATE**_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY # _____

FOR OFFICE USE ONLY:

I HEREBY AUTHORIZE AND REQUEST _____ TO PROVIDE MY MEDICAL RECORDS TO NJ GASTRO, LLC/ DR. DOMENICA BARRITTA FOR THE PURPOSES OF CONTINUED MEDICAL CARE.

PHONE _____ FAX _____

THE FOLLOWING MEDICAL RECORDS BEING REQUESTED ARE:

☐Endoscopy reports with pathology/biopsy

☐Colonoscopy reports with pathology/biopsy

☐ Labs
- ☐ Bloodwork
- ☐ Stool Studies
- ☐ Urinalysis
- ☐ Other: _____

☐ Radiology
- ☐ CT Scan_____
- ☐ Ultrasound _____
- ☐ MRI _____
- ☐ Other: _____

☐ Other records:

_____

_____ _____

PATIENT'S SIGNATURE **DATE**