David M. Feldman, M.D. FACP FACG — Gastroenterologist

Patient Information

Name (Last-First-Middle)	Sex	Social Security No.	Home Phone	Business Phone
Marital Status	Address (Home)		City	State / Zip Code
Employer Name	Address		City	State / Zip Code
Primary Care Physician	Primary Care Phone #		Primary Care Address	
Reason for Visit or Procedure			Date	

Spouse or Guardian	Relationship	Date of Birth	Social Security No.	Home Phone	Business Phone
Address			City	State	Zip Code
Employer	Address		City	State	Zip Code
Nearest Relative at Different Address	Relationship	Address	Home Phone	Business Phone	

Primary Insurance Information

Name of Insurance Company	Name of Insured			
Insured Date of BIrth	Policy Number	Group Number		
PPO or NON/PPO	Type of Insurance (Group / Private or Individual / HMO / Other)			
Address (Where to Submit Claim)	City	State	Zip Code	Phone Number

Secondary Insurance Information (If Applicable)

Name of Insurance Company	Name of Insured			
Insured Date of BIrth	Policy Number	Group Number		
PPO or NON/PPO	Type of Insurance (Group / Private or Individual / HMO / Other)			
Address (Where to Submit Claim)	City	State	Zip Code	Phone Number

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **"NOTICE OF PRIVACY PRACTICES"**.

Date: _____ Initials: _____

31 Washington Square West, Suite #3F, New York, NY 10011 • 212-366-0599

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INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made to **David M. Feldman, MD**. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

Date: _____ Signature: _____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **David M. Feldman, MD** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **David M. Feldman, MD** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Person Providing The Authorization (Signature): _____

Relationship To Patient If Not Patient: _____

ALTERNATIVE CONTACT AUTHORIZATION

I ☐**DO** ☐**DO NOT** authorize **David M. Feldman, MD** to contact me or leave messages for me at my place of work.

Date: _____ Initials: _____

I hereby authorize **David M. Feldman, MD** to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize I must call the office and make a follow-up appointment to obtain laboratory results.

Date: _____ Initials: _____

I ☐**DO** ☐**DO NOT** authorize **David M. Feldman, MD** to discuss my appointments, medical evaluation, treatment, and other results with relatives or other persons as indicated:

Authorized person(s)/relationship: _____

Date: _____ Initials: _____

ADVANCE DIRECTIVES (LIVING WILL)

I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I also acknowledge that:

I ☐**DO** ☐**DO NOT** have Advance Directives (either a Living Will or a Durable Power of Attorney for Health Care.) If I do not have such Advance Directives at this time, but establish them at a later date, I will provide the Office with a copy.

Date: _____ Initials: _____

David M. Feldman, MD FACP FACG

Medical & Family History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Medications — Please list all of your current prescription and non-prescription medications, vitamins and supplements:

☐ None

Past Medical History

☐ Acid reflux	☐ Cirrhosis of liver	☐ Groin hernia	☐ Kidney infection	☐ Polio
☐ Anemia	☐ Colon cancer	☐ Heart attack	☐ Kidney stones	☐ Psoriasis
☐ Arthritis	☐ Colon polyps	☐ Heart failure	☐ Lupus	☐ Radiation therapy
☐ Asthma	☐ Crohn's disease	☐ Heart murmur	☐ Migraines	☐ Rheumatic fever
☐ Bleeding disorder	☐ Depression	☐ Hepatitis	☐ Milk intolerance	☐ Sciatica
☐ Blood clots	☐ Diabetes	☐ Hiatal hernia	☐ Multiple sclerosis	☐ Seizures
☐ Blood transfusion	☐ Diverticulitis	☐ High blood pressure	☐ Osteoporosis	☐ Sleep apnea
☐ Cancer	☐ Duodenal ulcer	☐ High cholesterol	☐ Ovarian cyst	☐ Stomach ulcer
☐ Chest pain/angina	☐ Emphysema	☐ High triglycerides	☐ Pancreatitis	☐ Stroke or paralysis
☐ Chronic anxiety	☐ Fatty liver	☐ HIV or AIDS	☐ Parkinson's disease	☐ OTB (Tuberculosis)
☐ Chronic cough	☐ Gallstones	☐ Irregular heart beat	☐ Peptic ulcer	☐ TB skin test positive
☐ Chronic lung disease	☐ Glaucoma	☐ Irritable bowel syndrome	☐ Phlebitis	☐ Thyroid disease
☐ Chronic sinusitis	☐ Gout	☐ Kidney disease/failure	☐ Pneumonia	☐ Ulcerative colitis

Allergies

☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Latex ☐ Others: _____

Surgeries/Procedures

☐ None	☐ Colostomy	☐ Groin hernia	☐ Hiatal hernia repair	☐ Obesity surgery	☐ Thyroid
☐ Appendectomy	☐ C-section	☐ Heart bypass	☐ Hysterectomy	☐ Ovary	☐ Tonsillectomy
☐ Breast	☐ QEGD	☐ Heart stent	☐ Joint replacement	☐ Prostate	☐ Tubal ligation
☐ Colon surgery	☐ ERCP	☐ Heart valve	☐ Kidney	☐ Sigmoidoscopy	☐ Uterus
☐ Colonoscopy	☐ Gallbladder	☐ Hemorrhoid surgery	☐ Liver biopsy	☐ Stomach	☐ Other _____

Previous Hospitalizations

Reason	Date	Reason	Date

Family History

	Father	Mother	Grandparents	Siblings	Children
Healthy	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐
Ulcer disease	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Pancreas disease	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐
Stomach cancer	☐	☐	☐	☐	☐
Diabetes mellitus	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐

Social History

Marital Status	☐ married	☐ single	☐ divorced	☐ widowed
Occupation:	_____		☐ unemployed	☐ retired
Smoking history:	☐ never	☐ yes; _____ packs per day for _____ years		
Currently Smoking?	☐ no	☐ yes		
Other tobacco use	☐ no	☐ yes; details: _____		
Alcohol use	☐ no	☐ yes; amount per day: _____ for _____ years		
Drug use	☐ no	☐ yes; specify drugs and amounts: _____		
Exercise	☐ no	☐ yes; how much and how often: _____		
Hobbies	☐ none	☐ yes; specify: _____		
Recent travel outside US	☐ no	☐ yes; where: _____		

Review of Systems — check all that apply at the present time

General
- ☐fever or chills
- ☐loss of appetite
- ☐weight gain
- ☐weight loss
- ☐weakness, fatigue

Gastrointestinal
- ☐abdominal distention
- ☐abdominal pain/cramping
- ☐belching
- ☐black stools
- ☐blood in stool
- ☐change in bowel habits
- ☐constipation
- ☐diarrhea
- ☐difficulty swallowing
- ☐fat intolerance
- ☐full after eating small amounts
- ☐gas/bloating
- ☐heartburn
- ☐indigestion
- ☐hemorrhoids
- ☐jaundice
- ☐nausea or vomiting
- ☐pain with swallowing
- ☐poor appetite
- ☐rectal bleeding
- ☐rectal pain
- ☐regurgitation of food
- ☐soiling/incontinence
- ☐vomiting blood

Cardiovascular
- ☐chest pain or tightness
- ☐rapid or irregular heart beat
- ☐shortness of breath
- ☐swelling of legs
- ☐varicose veins

Respiratory
- ☐chronic cough
- ☐wheezing
- ☐shortness of breath
- ☐need for oxygen therapy

Urinary
- ☐pain or difficulty with urination
- ☐frequent urination
- ☐blood in urine
- ☐incontinence of urine

Musculoskeletal
- ☐stiff or painful joints
- ☐swollen joints
- ☐back pain
- ☐muscle pain

Hematologic
- ☐frequent bruising
- ☐bleeding doesn't stop easily

Endocrine
- ☐heat or cold intolerance
- ☐excessive thirst or urination
- ☐steroid therapy (prednisone)

Genitoreproductive - Male
- ☐discharge from penis
- ☐testicular pain or lump

Genitoreproductive - Female
- ☐heavy periods

date of last period:

Dermatologic
- ☐rash or hives
- ☐itching
- ☐tattoos

Neurologic
- ☐numbness or tingling
- ☐dizziness or lightheadedness
- ☐vertigo
- ☐headaches
- ☐weakness in arms or legs
- ☐blurred vision
- ☐difficulty with memory

Psychiatric
- ☐anxiety
- ☐depression
- ☐panic attacks
- ☐tired on waking up in morning

Immunizations
- ☐Hepatitis A
- ☐Hepatitis B