PATIENT INFORMATION FORM

Please print

NAME____
Last First M.I.

HOME ADDRESS____________________ CITY________________ STATE________ ZIP CODE________

HOME PHONE________________ WORK PHONE________________ CELL________________

SOCIAL SECURITY NUMBER ____________________ DATE OF BIRTH ________________ M__ F__

SPOUSE'S NAME________________________ PHONE________________

PHYSICIAN ____________________________ PHONE ________________

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY? ________________________________

PHONE ____________________

WHOM MAY WE THANK FOR REFERRING YOU TO US? ________________________________

PHONE ____________________

OCCUPATION ______________________ EMPLOYER NAME ______________________

EMPLOYER ADDRESS ____

INSURED NAME, IF NOT THE SAME:

NAME ____________________________ D.O.B. ______________

ADDRESS ______________________ CITY__________ STATE____ ZIP CODE ______________

PATIENT RELATION TO INSURED: ______ SELF ______ SPOUSE ______ CHILD ______ OTHER

MEDICARE? ______ YES ______ NO IF YES, NUMBER ____________________________

PRIMARY INSURANCE ____

POLICY NO: ________________________________ GROUP NO: ______________________

SECONDARY INSURANCE____

POLICY NO:________________________________ GROUP NO: ______________________

HEALTH PROXY: _____YES _____ NO

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? ______________________________

I WILL BE PAYING TODAY BY CASH ________ CHECK ________ CREDIT CARD________

I authorize any holder of Medical or other information about me to release to the Social Security Administration and Health Care Financing Administrations or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account of any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or of changes regarding the above information.

____ DATE ______________
Signature

____ DATE ______________
Parent's (if Minor) /Guardian's Signature

WILLIAM S. SILVER, MD&
ERIC L. TATAR, MD., PC
SVETLANA KORENFELD, MD
2 MEDICAL PARK DR
WEST NYACK NY 10994

ACKNOWLEDGEMENT

I ____
(PRINT PATIENT NAME)

Acknowledge that I have been provided with a copy of the HIPPA Notice and have been given the opportunity to read and ask questions about the notice.

If I am unreachable in any way, or anyone calls on my behalf I authorize the office to release medical information only to: (you may include family members and or doctors)

NAME RELATION PHONE #

1.____

2.____

3. ____

4.____

DATE: ____________________

X____
(PATIENT SIGNATURE / GUARDIAN IF MINOR)

William S. Silver, MD
Eric L. Tatar, MD
Svetlana Korenfeld, MD
2 Medical Park Dr
West Nyack NY 10094
Ph# 845-362-3300 Fax 845-362-8001

ABOUT YOUR INSURANCE BENEFITS

Thank you for choosing our practice as your health care provider. We are committed to providing you the best possible medical care. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please understand that payment of your bill is important.

Regarding Insurance :

It is **YOUR RESPONSIBILTY** to know and to advise us of your program's requirements in advance each and every time we schedule an appointment or provide a service to you. Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or laboratory that is outside of your program requirement, **you will be responsible for the appropriate fees.**
Always check with your insurance company before having any test done to ensure that the place of service you are going to accepts the insurance and that the test or tests you are having done are covered by your insurance company.

Referrals & PCP:

You are advised that the terms of your insurance benefit contract require you to obtain services from your participating insurance PCP and a referral form from your PCP before receiving the services you seek in order to be eligible for full benefit coverage related to this office visit.Please be further advised that the Provider indicated above has confirmed with your Insurance, if you proceed today to receive the services you seek in the absence of the required referral or confirmation of insurance coverage, the services will not be "covered services: under the terms of your benefit contract and you will be responsible for payment of amounts up to the providers FULL CHARGE for all services provided to you or your dependent. Pease note that the PCP and Referral on file cannot be backdated. It is your right to contact your Insurance company to change your PCP and have the right to arrange for the required referral before receiving the services you seek in order to have full benefits under the terms of your Insurance Benefit contract.

Missed Appointments:

Due to the number of patients needing appointments, we must request at least 48 hours advance notice when you need to cancel or reschedule your appointment. **It is our policy to charge a $75.00 cancellation fee if given less than 48 hours notice for any procedure appointments!!!**

Patient Balances: If payment is not received within 30 days of the statement, a late fee may be applied to your balance each month until payment is received.

ASSIGNMENTS OF BENEFITS

I hereby authorize direct payment of medical benefits to William S Silver & Eric L Tatar, MD PC for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-=insurance, and denied (non-covered) services.

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behal. A photocopy of these assignments shall be valid as an original.

Signature: ____Date:___________

Name:____Date:__________

Signature of Parent/Guardian (if minor): ________________________Date:__________

RELEASE OF INFORMATION

I authorize William S Silver, MD & Eric L Tatar, MD , Svetlana Korenfeld, MD ,PC to release any necessary medical information to process my insurance claims.

Signature: ____Date:____________

Signature of Parent/Guardian(if minor):_________________________Date:_____________

GUARANTEE OF PAYMENT

In consideration of services rendered by William S Silver, MD & Eric L Tatar, MD PC, I, the undersigned, agree to pay William S Silver, MD & Eric L Tatar, MD PC . any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

Signature:____Date:___________

Signature of Parent/Guardian (if minor):__________________________Date:____________

William S. Silver, MD
Eric L. Tatar, MD
Svetlana Korenfeld, MD

2 Medical Park Dr
West Nyack, NY 10994

(T) 845-362-3300
(F) 845-362-8001

OFFICE CANCELLATION POLICY

Please be aware there is a $75.00 cancellation fee if given less than 48 hours notice for procedures.

This fee is NOT covered by your insurance company.

Thank you for your cooperation.

Signature ______________________________ Date ____________

NAME:______________________________________ DATE:____________________

REASON for VISIT TODAY: ____
____

Patient Questionnaire – Anorectal Health (If pertain to this visit)

Bowel & Dietary Habits (*Circle either Yes or No for each answer*)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? ____________Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**
7. Are you taking any fiber supplements? **Y / N**

a. If yes, which one(s)? ______________________________

8. On average, do you drink the equivalent of 6-8 glasses of water per day? **Y / N**

Symptoms (in Rectal Area) (*Check all that apply*)

☐ Bleeding ☐ Itching ☐ Prolapse

☐ Pressure or Swelling ☐ Leaking or Soiling ☐ Pain ☐ Burning

Additional Questions (*Circle either Yes or No for each answer*)

1. Are you allergic to latex? **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any erectile dysfunction medicine for ED, any Viagra for hypertension, Cialis for your prostate or any nitrates for chest pain? **Y / N**
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**
6. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
7. Do you need to take antibiotics before having dental or other procedures? **Y / N**

PLEASE inform or PROVIDE front desk staff of any recent labs or radiology imaging you have had. Thank you.

William S Silver MD & Eric L Tatar MD PC
Svetlana Korenfeld MD
2 Medical Park Drive, Suite 14
West Nyack, NY 10994
845-362-3300
Fax 845-362-8001

Patient Interview Form

Patient Information

First Name: ____________________ Last Name: ____________________
Date Of Birth: ____________________ Age: ____________________
Height: Weight:

Email
Please check one as your preferred email for communications
◯ Personal: ____________________ ◯ Work: ____________________

Race
Select one or more
◯ White ◯ Black or African American ◯ Asian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander
◯ Unknown ◯ Patient declines to specify ◯ Prohibited by state law

Ethnicity
◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify ◯ Prohibited by state law

Sex
◯ Male ◯ Female ◯ Other

Preferred Language
◯ English ◯ Patient declines to specify

Contact Preference
◯ Phone- Can leave a message on any number ◯ Email ◯ Patient Portal ◯ Cell phone ◯ Work Phone
◯ Patient declines to specify Other: __________

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies
◯ Penicillins ◯ Sulfa (Sulfonamides) ◯ Eggs ◯ Soy Other: __________

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

- None
- Hep A, adult — When:
- Hep B, adult — When:
- Pneumonia — When:
- Other:

Diagnostic Studies/Tests

- None
- CT Abdomen/Pelvis — When:
- Abdominal Ultrasound — When:
- MRI — When:
- Colonoscopy — When:
- EGD — When:
- Other:

Past or Present Medical Conditions

- None

Cardiovascular

- Atrial Fibrilation
- Coronary Heart Disease
- Deep vein thrombosis
- High blood pressure
- Myocardial infarction
- Stroke
- High Cholesterol
- Heart Murmur

Pulmonary

- Asthma
- Emphysema
- COPD

Other

- Arthritis
- Back Pain (chronic)
- Diabetes Mellitus
- Glaucoma
- Hypothyroidism
- Kidney Disease
- Liver Disease
- Bleeding Disorder
- GERD
- HIV
- Other:

Previous Procedures

- None
- Cholecystectomy — When:
- Appendectomy — When:
- Hysterectomy — When:
- Colonoscopy — When:

Other Surgeries:

Social History

Occupation:

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Alcohol

- None
- Yes

Type	Quantity	Number	Frequency

Caffeine

- None

- Occasional
- Moderate
- Heavy
- # of cups per day

Intake: ______________________

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Drug Use

- None
- Used IV drugs in the past
- Uses IV drugs currently
- Recreational drug use

Type: ______________________

Exercise

- None

Type	Quantity	Number	Frequency
Jogging			
Cardio			
walking			
Other			

Family Medical History

- No knowledge of family history

No family history of

- Celiac sprue
- Colon polyps
- Ulcerative colitis/Crohn's
- Colon cancer
- Liver disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Other
Alcoholism	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○
Pancreatic disease	○	○	○	○	○	○	○
Heart disease	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Other cancer	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Ulcerative colitis/Crohns Disease	○	○	○	○	○	○	○

Review Of Systems -PLEASE CHECK ALL THAT APPLY AT THIS VISIT ONLY

Allergic/Immunologic

◯ None	Y	N
Frequent sneezing	◯	◯
Hives	◯	◯
Itching	◯	◯
Runny Nose	◯	◯
Sinus Pressure	◯	◯

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
dyspnea with exercise	◯	◯
irregular heart beat	◯	◯
orthopnea	◯	◯
palpitations	◯	◯
peripheral edema	◯	◯
syncope	◯	◯

Constitutional

◯ None	Y	N
fatigue	◯	◯
fever	◯	◯
loss of appetite	◯	◯
malaise	◯	◯
sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯
dizziness	◯	◯
ear pain	◯	◯
nasal obstruction	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯

Endocrine

◯ None	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Eyes

◯ None	Y	N
double vision	◯	◯
loss of vision	◯	◯
photophobia	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
hemorrhoids	◯	◯
jaundice	◯	◯
nausea	◯	◯
black stools	◯	◯
rectal bleeding	◯	◯
stomach cramps	◯	◯
vomiting	◯	◯
odynophagia	◯	◯
difficulty swallowing	◯	◯

Genitourinary

◯ None	Y	N
dark urine	◯	◯
decrease in urine flow	◯	◯
dysuria	◯	◯
frequent urinary infections	◯	◯
frequent urination	◯	◯
hematuria	◯	◯
impotence	◯	◯
nocturia	◯	◯
urethral discharge or incontinence	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
bleeding gums or palpable lymph nodes	◯	◯
easy bruising	◯	◯
prolonged bleeding	◯	◯

Integumentary

◯ None	Y	N
allergies	◯	◯
dryness	◯	◯
hives	◯	◯
itching	◯	◯
jaundice	◯	◯
lesions	◯	◯
rashes	◯	◯

Musculoskeletal

◯ None	Y	N
arthritis	◯	◯
back pain	◯	◯
gout	◯	◯
joint deformity	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯
stiffness	◯	◯

Neurological

◯ None	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯
memory loss	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
hallucinations	◯	◯
nervousness	◯	◯
panic attacks	◯	◯
paranoia	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
excessive sputum	◯	◯
coughing up blood	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature Date