Ricardo E. Rodriguez MD, PA
GASTROENTEROLOGY
318 E. Westfield Ave.
Roselle Park, NJ 07204
Tel: 908-245-2229 Fax: 908-245-2384

PATIENT ENROLLMENT

Name: _____ **Date of Birth:** _____
Last First

Address: _____ **Apt. /Floor:** _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone#: (Home): _____ **Cell #:** _____ **SS#:** _____

Marital Status: _____ **Race:** _____

Occupation: _____

Employer Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

Emergency Contact: _____ **Telephone:** _____ **Relationship:** _____

Referring MD _____ ***Allergies:*** _____

Primary Care Provider: _____

Primary Insurance Information

Company: _____ **ID#:** _____ **Group #:** _____

Claims Mailing Address: _____

Subscriber Name (if other than the patient): _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: _____ **SS#:** _____ **Relationship to Patient:** _____

Secondary Insurance Information

Company: _____ **ID#:** _____ **Group #:** _____

Claims Mailing Address: _____

Subscriber Name (if other than the patient): _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: _____ **SS#:** _____ **Relationship to Patient:** _____

I have been given information on privacy, patient rights and advanced directives by my provider and I understand that my provider is one of the owners of Garden State Endoscopy & Surgery Center.

_____ _____
PATIENT SIGNATURE DATE

Please provide your insurance card (s) and picture I.D. and proof of address to the receptionist.
Thank you very much.

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PATIENT CONFIDENTIALITY

Patient Confidentiality is a prime concern in this office. Please indicate below with whom our office can or cannot leave a message.

Please check one where appropriate.

	YES	NO	PHONE#	N/A
Spouse	____	____	_____	_____
Children	____	____	_____	_____
Answering Machine	____	____	_____	_____
E-mail Address	____	____	_____	_____

(Your address, if yes) _____

Are you able to receive calls at your workplace? Yes ____ No ____

May we call you at your workplace and state who is calling? Yes ____ No ____

Due to our confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you – the patient.

Please check with whom we may discuss your situation.

	YES	NO	N/A
Spouse	_____	_____	_____
Children	_____	_____	_____
Other	_____	_____	_____

Children &/or Significant Others

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

Please Sign: _____ Date: _____

Witness: _____ Date: _____

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MEDICATION LIST

PATIENTS NAME: _____ DATE: _____

PHARMACY: _____

PHARMACY ADDRESS: _____ PHONE: _____

ALLERGIES: _____

MEDICATION	DOSAGE	FREQUENCY	DATE OF LAST DOSE

Attestation:

I verify that the list is complete and accurate to the best of my knowledge which I provided to be included in my medical record.

This list includes any over the counter medications and herbal supplements, as well as regular and occasionally used prescription drugs.

Patient Signature/responsible adult: _____ Date: _____

Name: _____ DOB : _____ Date : _____

Have you had any of these problems in the past six months?

General

__Breast lump/pain/mass/changes
__Thyroid/neck cyst/mass
__Fatigue
__Loss of appetite
__Excessive thirst/hunger
__Weight loss
__Night sweats
__Fever/chills

Ear, Nose, Throat

__Tooth abscess/gum infection
__Hearing loss
__Ringing in the ear
__Nasal discharge
__Nose bleed
__Sinusitis
__Throat infection/pain

Eye

__Double vision
__Ear pain/discharge
__Blurry vision
__Cataracts
__Glaucoma

Dermatology

__Skin rash/skin changes
__Varicose veins

Musculoskeletal

__Muscle Weakness
__Joint/muscle pain
__Back pain

Cardiology

__Shortness of breath
__Chest pain
__Palpitations
__Leg swelling

Gastrointestinal

__Excessive intestinal gas
__Difficulty swallowing
__Abdominal pain
__Nausea
__Vomiting

__Change in stool/bowel movements
__Abdominal bloating
__Diarrhea

__Constipation
__Rectal bleeding
__Heartburn
__Stool incontinence

Genitourinary

__Enlarged lymph glands
__Difficulty with urination)
__Blood in urine/changes in urination
__Excessive vaginal bleeding
__Pregnancies
__Vaginal discharge
__Penile discharge

Neurology

__Headaches
__Vertigo/dizziness
__Loss of consciousness
__Convulsions
__Facial numbness/weakness
__Abnormal skin sensation
__Memory loss
__Poor muscle strength

Psychiatry

__Anxiety/depression/insomnia)

Infectious

__Contagious diseases/STD/HIV/hepatitis

Endocrine

__Heat/cold sensitivity

Respiratory

__ TB Test
__Wheezing/ respiratory sounds
__Cough
__Hay fever
__Coughing blood

Name: _____ DOB: _____ Date: _____

Ricardo E. Rodriguez M. D.

Medical History

Please indicate if you've had any of the following illnesses or medical conditions:

Yes	No	
___	___	Anemia
___	___	Arthritis/Osteoporosis
___	___	Cancer
___	___	Diabetes
___	___	Thyroid Disease
___	___	Glaucoma
___	___	Cardiac Disease/Valvular Disease
		___ Heart attack
		___ Pacemaker or Defibrillator
		___ Echocardiogram/EKG
		___ Coronary Angioplasty
		___ Coronary Bypass Surgery
		___ Coronary Stent Placement
		___ Cardiac Catheterization
		___Valve Surgery
___	___	Emphysema/Bronchitis/Asthma
___	___	Digestive Liver/Gallbladder/Pancreas Disease
___	___	Renal Disease
___	___	Uterus/Ovarian/Cervix Disease
___	___	Prostatic Disease
___	___	Blood/Coagulation Disease
___	___	Vascular Disease
___	___	Hypertension
___	___	AIDS/HIV/Infections
___	___	Have you received blood transfusions
___	___	Female (Pregnant)
___	___	Drug use/other remedies
___	___	Other Illnesses

_____

Surgical History

Surgeries:

_____

Family History

___ ___ Liver/Intestine/Pancreas/Stomach/Biliary Cancer

_____