TOMASZ J. NIEWIARowski M.D.

Patient Name: _____ Age: _____
(last) (first) (middle)

Birthdate: _____ Sex: Male Female

Address: _____
(Number/Street) (City/State) (Zip Code)

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Spouse Cell: _____

Marital Status: _____ Email: _____

Social Security : _____

Employer Name and Address : _____

Family Doctor: _____
Doctor Name Address/Phone

Referring Doctor: : _____
Doctor Name Address/Phone

Insurance: Primary: _____ Effective Date: _____
ID: _____Group _____
Subscriber: _____

Insurance: Secondary _____ Effective Date: _____
ID: _____Group _____
Subscriber: _____

Spouse Name: _____ Birthdate: _____
Spouse Social Security _____

I understand that fees for services rendered by Tomasz J Niewiarowski, M.D. are payable to same by myself or my insurance carrier (if assignment of benefits is not accept, I understand I am responsible for the remaining balance, including deductible or co-payments). I authorize Tomasz J Niewiarowski, M.D. to release my insurance company any information necessary to complete claims. I further authorize payment to medical benefits by my insurance company to Tomasz J Niewiarowski, M.D.

Signature: _____ Date: _____

Vita Medical Associates, PC
Tomasz J Niewiarowski, MD
306 S New Street, Bethlehem, PA 18015
Tel: (610) 974-9540, Fax: (610) 974-8589

Medical History

1. Patient Name: _____ Age: _____
   (last) (first) (middle)
   Birthdate: _____ Sex: Male Female

2. Please briefly describe your current problem that brings you to the office:
   _____

3. List all your medications
   _____
   _____
   _____

4. Allergies to medications
   _____

5. Your family medical history
   Family history of cancer: Colon, pancreatic or other cancers:
   _____
   _____
   Other gastrointestinal disorders in your family: Celiac sprue, Crohn's disease, ulcerative colitis, hemochromatosis, liver disease, other: _____
   Other medical issues in your family: _____

6. Do you experience any of the following? Check all that apply:
   - Weight loss/gain. If yes, how much over the last 3 months: _____
   - Fatigue: mild moderate severe
   - Abdominal pain, if yes describe : _____
   - Bloating, upper abdominal fullness of eating, excessive belching.
   - Heartburn, regurgitation of food, acid reflux, sour taste
   - Nausea, vomiting, difficulty swallowing, painful swallowing
   - Black stools, blood in stools
   - Constipation – describe stool frequency: _____/week. Stool consistency: very firm, firm, soft
   - Diarrhea – describe stool frequency: _____/week. Stool consistency: watery, semi-formed, loose
   - Loss of appetite
   - Fever, chills, sweating
   - Chest pain, shortness of breath, Cough
   - Irregular heart beat
   - Joint pain, back pain, headaches, any other chronic pain
   - Depression, anxiety
   - Difficulty walking, weakness in arms and legs, numbness, abnormal sensation, loss of sensation

7. Your social history:

   Smoking: Currently _____ How Much? _____ Quit: _____

   Alcohol: Quantity and frequency: _____

   Recreational, Injectable, illicit drugs:

   If yes, explain: _____

   Were you ever treated for drug/alcohol dependence or addiction? If yes, please provider details:

8. Your Medical history:

   Do you have history of any of the following conditions? Please mark all that apply:

Diabetes	High blood pressure	Elevated lipids	Stroke
Heart Disease	Coronary artery stent	Cardia surgery/CABG	Asthma
Artificial heart valve, if yes: mechanical or bio-prosthetic			
Atrial fibrillation	Pacemaker	Implantable defibrillator	Sleep Apnea
Blood Clots	Pulmonary embolus	Excessive bleeding	
Psychiatric Illness	Depression/Anxiety	Bipolar disorder	Schizophrenia
Fibromyalgia	Chronic Pain	joint pain/ arthritis	Back pain
Pancreatitis	Hepatitis C	Hepatitis B	HIV infection

   History of cancer, if yes, what kind of cancer? _____

   How treated? Surgery Chemotherapy Radiation Therapy How long ago? _____

   Any other significant medical history:

   _____

   _____

   Your surgical history. Did you have any surgeries? Mark all that apply:

None			
Gallbladder (cholecystectomy)	bowel resection	appendectomy	gastric resection
Gastric bypass	gastric sleeve	anti-reflux surgery	hysterectomy
Prostate surgery	hernia surgery		

   Any other surgeries: _____

9. Your prior gastrointestinal procedures of imaging. Mark all that apply:

   None

   Colonoscopy: When: _____ What were the findings: _____

   EGD (Upper endoscopy): When: _____ What were the findings: _____

   ERCP: _____ Biliary stone removal : _____

   EUS (endoscopic ultrasound) _____

   Recent CT Scan of abdomen abdominal ultrasound MRI of the abdomen

10. Your vaccination history, Were you vaccinated against?

Hepatitis A	Hepatitis B	Influenza/Flu	Pneumonia/Pneumovax
HPV	Tetanus booster	Other Vaccines:	

11. Do you routinely:

    - Obtain mammograms? Yes/No Date of last exam: _____
    - PAP Smears? Yes/NO Date of last exam: _____
    - Prostate cancer screening? Yes/No Date of last exam: _____

Vita Medical Associates P.C. – Gastroenterology
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Bethlehem, PA 18015
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Tomasz J. Niewiarowski M.D.

AUTHORIZATION

I, _____, authorize Tomasz Niewiarowski, M.D. to forward medical records regarding my ongoing treatment to the following parties:

Physician	Address	Dates Treated

I understand that I may change this list at any time and I am responsible to keep Dr. Tomasz Niewiarowski, apprised of any changes to this list. This authorization is to stay in effect until another signed authorization form is issue and signed by me.

Patient or Guardian's Signature: _____ Date: _____

Print Name of Patient: _____

Witness Signature: _____ Date: _____

Print Name of Witness: _____

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgment of notice and consent authorizes VITA Medical Associates, P.C. to use and disclose health information about your for treatment , payment, and healthcare operations purposes.

Notice of Privacy Practices: VITA Medical Associates, P.C. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signed this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to Contact our Privacy Officer

Mail: VITA Medical Associates, P.C.
Attn: Privacy Officer
306 S. New Street Suite 201
Bethlehem, PA 18015
Telephone: 610-866-0113
Fax: 610-974-8589

Acknowledgement and Consent

Print or type all information except signature

I have received the Notice of Privacy Practices for VITA Medical Associates, P.C. and authorize them to use and disclose health information about _____ (patient name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Name of personal representative Relationship to patient

COMMUNICATIONS CONSENT

VITA MEDICAL ASSOCIATES, P C

It is the office policy of VITA Medical Associates, P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell home and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize VITA Medical Associates, P.C. and/or their staff to leave medical information pertaining to my care by the following methods and will assume reasonability to notify them whenever this information changes.

Home Phone:	_____	**yes**	**no**
Answering Machine :	_____	**yes**	**no**
Work Phone (Voicemail) :	_____	**yes**	**no**
Cell Phone:	_____	**yes**	**no**
Email Address:	_____	**yes**	**no**
Send/Receive medical records/Electronic prescription history for referrals to other doctors		**yes**	**no**

If you would like to have information released to someone other than yourself please complete the following:

Please list names and phone numbers of authorized people:

Spouse: _____ Phone: _____
Parent: _____ Phone: _____
Other: _____ Phone: _____
Other: _____ Phone: _____

Printed Name: _____
Signature: _____ **Date:** _____

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Tomasz J. Niewiarowski M.D.

Financial Policy

We are committed to providing your with the best possible care. In order to achieve these goals, we need your assistance and your understanding our payment policy.

We are Blue Cross/ Blue Shield and Medicare participating providers as well as participating providers with several other insurance plans/networks. Not all services are a covered benefit by all insurance companies, therefore, any service not covered by your insurance will be your responsibility. If you have any questions regarding your insurance coverage, it is your responsibility to contact your insurance carrier. It is your responsibility to check with your insurance carrier regarding pre-certification and/or second opinion coverage, procedures or clinical studies. Should you need any assistance, our staff will be happy to help you.

Your insurance is a contract between you and the insurance company. If your insurance company requires a referral form, this must be brought at the time of the visit. If it is an electronic referral, it would be greatly appreciated if you would bring the referral number. If you do not bring the referral, we will need to reschedule your appointment or you can pay for the charges on that day. Without referrals, we cannot bill your insurance company and therefore, the patient is billed directly. All office visits, patient responsible, copays are due the day of service.

All charges are your responsibility form the date of service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance. There are many options the billing department can offer such as payment plans, copay foundations, and drug copays cards.

I understand that fees for services rendered by any physician and/or employee of Vita Medical Associates P.C. are payable to same by myself or my insurance carrier(if assignment of benefits is not accepted, I understand I am responsible for the remaining balance, including deductibles, or co-payments, upon receipt of the first billing statement). I authorize Vita Medical Associates P.C. to release to my insurance company any information necessary to complete claims. I further authorize payment of medical benefits by my insurance company to Vita Medical Associates P.C.

Patient or Guardian's Signature: _____ Date: _____

Print Name of Patient: _____

Witness Signature: _____ Date: _____

Print Name of Witness: _____