Tomasz J. Niewiarowski, M.D. & James J. Boylan, M.D.
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Tel: (610) 866-0113 – Fax (610) 974-8589

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VITA Medical Associates, P.C.
MEDICAL HISTORY

1. **Patient's Name:** _____ Age: _____ **Date:** _____
(Last) (First) (Middle)
Date of Birth: _____ **Sex:** Male Female

2. **Please briefly describe your current problem that brings you into our office:**
_____

3. **CURRENT MEDICATIONS: (**Please use additional paper if necessary)

4. **ALLERGIES:** _____

5. **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?** (Please check all that apply):
- Abdominal Pain, if yes describe: _____
- Black Stools, Blood in Stools
- Bloating, Upper Abdominal Fullness of Eating, Excessive Belching, Excessive Gas
- Chest Pain, Shortness of Breath, Cough
- Constipation – Describe Stool Frequency: _____/week. Stool Consistency: Very Firm, Firm, Soft
- Depression, Anxiety
- Diarrhea – Describe Stool Frequency: _____/week. Stool Consistency: Watery, Semi-Formed, Loose
- Difficulty Walking, Weakness in Arms and Legs, Numbness, Abnormal Sensation, Loss of Sensation
- Fatigue: Mild Moderate Severe
- Fever, Chills, Sweating
- Heartburn, Regurgitation of Food, Acid Reflux, Sour Taste
- Irregular Heartbeat
- Joint Pain, Back Pain, Headaches, any other Chronic Pain
- Loss of Appetite
- Nausea, Vomiting, Difficulty Swallowing, Painful Swallowing
- Weight loss/gain. If yes, how much over the last 3 months: _____

7. **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 provide details:

_____

8. **MEDICAL HISTORY:**

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

Diabetes	Bipolar Disorder
Heart Disease	Psychiatric Illness
Artificial Heart Valve, if yes: mechanical or bio-prosthetic	Depression/Anxiety
Atrial Fibrillation	Schizophrenia
Blood Clots	Hepatitis B
Pulmonary Embolus	Hepatitis C
High Blood Pressure	HIV Infection
Coronary Artery Stent	Fibromyalgia
Cardiac surgery/CABG	Back Pain
Implantable Defibrillator	Chronic Pain
Pacemaker	Joint Pain/Arthritis
Stroke	Excessive Bleeding
Asthma	Elevated Lipids
Sleep Apnea	Pancreatitis

History of Cancer, if yes, What Kind of Cancer?

_____

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

OTHER SIGNIFICANT MEDICAL HISTORY:

_____

SURGICAL HISTORY: Did you have any surgeries? (Please mark all that apply):

None

Anti-Reflux Surgery	Gastric Bypass	Hernia Surgery
Appendectomy	Gastric Resection	Hysterectomy
Bowel Resection	Gastric Sleeve	Prostate Surgery
Gallbladder (*cholecystectomy*)	Any Other Surgeries: _____	

9. **PREVIOUS GASTROINTESTINAL IMAGING** (Please 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 - Abdomen _____ Abdominal Ultrasound _____ MRI/MRCP Abdomen _____

10. **VACCINATION HISTORY:** Were you vaccinated against? (Please provide dates, if known).

Covid-19	_____	(1st) _____ (2nd) _____
Hepatitis A	_____	
Hepatitis B	_____	
HPV	_____	
Influenza/Flu	_____	
Other Vaccines:	_____	
Pneumonia/Pneumovax	_____	
Tetanus Booster	_____	

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: _____

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Date of Birth:_____-_____-_____ *Social Security Number:_____-_____-_____

Gender: □ **Male** □ **Female**

Marital Status: □ **Married** □ **Single** □ **Divorced**

□ **Separated** □ **Widowed** □ **Life Partner**

Home Address:

_____

Street No./Street Name **Apt #** **City** **State** **Zip Code**

Home Phone: _____ Cell Phone: _____

Work Phone: _____ *Email Address: _____ (if none, put N/A)

PRIMARY INSURANCE: _____ID#: _____

SUBSCRIBER:_____DOB:_____

Pharmacy Name: _____

Pharmacy Address: _____ Telephone: _____

PHYSICIAN NAME / REFERRAL INFORMATION

Primary Care Physician's Name:_____

_____

Address **Telephone No.**

Referring Physician's Name: _____
(FOR NEW PATIENT'S ONLY)

_____

Address **Telephone No.**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name: _____ First Name:_____

Relationship to Patient: _____

Address: _____
Street No./Street Name Apt # City State Zip Code

Home Phone: _____ Cell Phone:_____

Work Phone: _____

SECONDARY EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name:_____

Relationship to Patient: _____

Address: _____
Street No./Street Name Apt # City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____

I understand that fees for services rendered by **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). I authorize **VITA Medical Associates, P.C.** to release to my insurance company any information necessary to complete claims. I further authorize payments to medical benefits by my insurance company to **VITA Medical Associates, P.C.**

SIGNATURE: _____ DATE: _____

Information Entered by: ____

PHARMACY INFORMATION

Pharmacy Plan Name: _____

Card Holder's Name: _____

BIN #: _____

PCN #: _____

POLICY ID #: _____

RX GROUP #: _____

Pharmacy Name: _____

Pharmacy Phone No.: _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of 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 services 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 in 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. Patients are responsible to make "co-pay" payments the day of service.

All charges are your responsibility from the date the services are 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, co-pay foundations, and drug co-pay 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: _____

Witness Signature: _____ Date: _____

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

Please read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **VITA Medical Associates, P.C.** to use and disclose health information about you 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 signing 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 for 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's Name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient (or Patient's Personal Representative) Date

Personal Representative Information (if applicable):

_____ _____
Name of Personal Representative Relationship to Patient (or Other Authority)

COMMUNICATION CONSENT

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 and/or cell phone number. 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 responsibility to notify them whenever this information changes:

Cell Phone and/or Voice Mail:_____ Yes No

Work Phone and/or Voice Mail:_____ Yes No

Home Phone/or Voicemail: _____ Yes No

E-mail Address: _____ Yes No

Send/Receive Medical Records/Electronic Prescription
History for Referrals to Other Doctor's Facilities Yes No

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

Please list the names of authorized people:

Spouse: _____ Phone: _____

Life Partner: _____ Phone: _____

Other Names (Please list relationships such as boyfriend, fiancé, girlfriend, sister, brother, etc.) Yes No

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Printed Name: _____

Patient/Guardian Signature: _____ Date:_____