Joseph DeAntonio, MD
Lawrence Gastroenterology
3100 Princeton Pike
Building 4, Suite C
Phone: 609-882-2185
Fax: 609-882-0347
www.lawrencegastro.com
Portal: emr.ehiconnect.com/p

NEW PATIENT PACKET

Please include a photocopy of your drivers license and insurance (back and front).

Bring all pertinent labs or radiological studies

Patient

Last Name:_____First Name:_____Date of Birth (m/d/y):___/__/___

Social Security Number:_____ Gender: F M Married:__Yes__No

Phone Number: Home:_____Cell:_____Email:_____

Mailing Address:_____

Employer:_____

Responsible Party

Last Name:_____First Name:_____

Phone Number:_____Cell:_____

Mailing Address:_____

Employer:_____

Government Required Questions

Non-Hispanic or Latino ☐ Hispanic or Latino ☐

If you refuse to answer the questions, why?_____

American Indian or Alaska Native ☐ Asian ☐ White ☐ Hispanic or Latino ☐

Native Hawaiian or other Pacific Islander ☐ Black or African American: ☐

If you refuse to answer the questions, why?_____

What language do you speak: _____

Pharmacy Name:_____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Insurance Information

All patients with more than one insurance plan must coordinate their benefits (COB) annually or if there is any change in insurance coverage. Each insurance company must be told by the patient what plans the patient has and which is their primary, secondary and tertiary. Claims which remain unpaid due to lack of COB will be billed to the patient directly.

Primary Insurance

Insurance Company: _____ Member ID: _____ Group #: _____

Subscriber's Name :_____ DOB: _____

Subscriber's relationship to patient: _____ Phone Number: _____

Secondary Insurance

Insurance Company: _____ Member ID: _____ Group #: _____

Subscriber's Name :_____ DOB: _____

Subscriber's relationship to patient: _____ Phone Number: _____

Tertiary Insurance

Insurance Company: _____ Member ID: _____ Group #: _____

Subscriber's Name :_____ DOB: _____

Subscriber's relationship to patient: _____ Phone Number: _____

Patient Portal

We will no longer mail lab, pathology or radiology results. Your patient portal will now have all this information posted. This allows you easy access to your personal health information. You will be given a username and password when you come for your appointment or if you schedule an open access colonoscopy. The link to the portal (https://emr.ehiconnect.com/p) is and is posted on our website (www.lawrencegastro.com). You may change your password once you sign in. Please follow the appropriate steps on the portal login if you have forgotten your password.

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____ hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medication to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor. I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, CT Scan, colonoscopy or endoscopy this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks. I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow this advice should be expected.

Patient's Signature _____ Date _____

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the highest quality of care. In order to provide this care, it is essential that our office run as efficiently as possible. Proper payment of a bill is an important part of the process.

Missed Appointments: If for any reason you cannot keep your appointment please call as soon as possible to cancel or reschedule. There is a $50.00 charge for all missed office appointments and $75.00 for missed procedures, you must cancel or reschedule your office appointment 48 hours in advance to avoid this charge and 72 hours in advance for procedure appointments.

General Insurance Information: *Your insurance policy is a contract between you and the insurance company. It is essential that you understand your benefits and obligations under that agreement.* Please call your insurance company to determine that Dr. Joseph DeAntonio is a network provider for that company. As a courtesy, we file insurance claims on your behalf. It is understood that the payments will be assigned to Lawrence Gastroenterology. We cannot bill your insurance carrier correctly unless you provide your current insurance information. Patients with more than one insurance carrier MUST coordinate their benefits with all insurance carriers every 6 months. Confusion of this carriers can lead to long delays in payment or no payment. In this case you will be responsible for the full bill.

Medicare Payment Policy: Lawrence Gastroenterology is a participating provider under Medicare. Which means Medicare will pay 80% of the Medicare allowable charge, after your deductible is met. The remaining 20% will be submitted to the supplemental insurance plan. Deductibles and the remaining uncovered balance are your financial responsibility.

Referrals: Some insurance policies require an electronic referral from your primary care physician (PCP) prior to seeing a specialist. *Please check with your insurance company if a referral is needed, it is the patient's responsibility to have a referral created.* Some PCPs require 2 weeks to grant a referral therefore, contact them several weeks before your visit with us. *If the referrals are not obtained at the time of service, the patient will be personally responsible for all charges*. Referrals often have an expiration date and a limited number of visits so please monitor the dates and visits.

Co-payments, Coinsurance and Deductibles: Patients are responsible for paying co-payments (at the time of service), coinsurance and deductibles. Most insurance carriers pay a percentage of their allowable fees, the coinsurance is the remaining unpaid portion of the fee. Each year your insurance carrier requires you to pay a set amount out of pocket, this is your deductible. We will bill you for these charges and you are legally responsible for them.

Past Due Accounts and returned Checks: After the insurance carrier has paid their portion of the bill you will be responsible for the remaining balance of their set fees. We will send you a bill. A balance due after 90 days will result in the transfer of the responsible patty's account to a collection agency. You will be responsible for your balance and the collection agency's fees. Your account will be charged $35.00 for each returned check.

Lawrence Gastroenterology my refuse to treat me.

Patient's Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Reason for your visit (chief complaint): _____

Referring Physician: _____

Past Medical History (circle the options that pertain to you)

High Blood Pressure	Diabetes	Heart Disease	Heart Attack
Asthma	Emphysema	Seizures	Heart Murmur
Rheumatic Fever	Colitis	Crohn's Disease	High Cholesterol
Arthritis	Thyroid Disease	Kidney Failure	HIV

Cancer please specify type: _____ Date of diagnosis: _____

Allergies (circle the options that pertain to you)

Latex Sulfa Penicillin Aspirin Other: _____

Past Surgery

Type and dates: _____

_____

_____

Medications

Please list, including over the counter products and vitamins

MEDICATION	TIME TAKEN AM/PM	DOSAGE TAKEN AT THIS TIME
Example	8:00 AM and 8:00 PM	20 mg

Past Colonoscopies

Have you had a colonoscopy in the past? YES NO

If you answered yes was it preformed by Dr. DeAntonio? YES NO

If Dr. DeAntonio did not preform the colonoscopy, who did? _____

The doctor's address and phone #:_____

Date of last colonoscopy: _____

Family History of Cancer

Mother: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Father: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Sibling: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Sibling: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Sibling: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Grand Parents: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Grand Parents: cancer of _____ at the age of _____ Heart Disease: YES NO High Blood Pressure: YES NO

Patient Name: _____ Date of Birth: _____

Symptoms (circle the options that pertain to you)

Poor Appetite	Headache	Chest Pain
Nausea	Dizziness	Trouble Breathing
Vomiting	Passing Out	Heart Murmur
Heart Burn	Eyeglasses	Heart Palpitations
Difficulty Swallowing	Vision Trouble	Coughing
History of Ulcers	Sinus Congestion	Wheezing
Diarrhea	Sore Throat	Other Heart or Breathing problems:
Constipation	Arthritis	
Rectal Bleeding	Skin Rash	Cardiac Stents
Abdominal Pain	Leg Swelling	Number of Pregnancies
Altered Bowel Habits	Take Antibiotics for dental work	Number of Births
History of Colon Polyps	Urinate Frequently	History of Pelvic Infections
Trouble with Blood Clotting	Burning when urinating	Last Menstrual Period
Jaundice	Blood in urine	Last Mammogram
History of Hepatitis	Kidney Stones	Smoker Packs/Day
History of Blood Transfusions	Incontinence	Alcohol Drinks/Day
Itching	Other urinary problems:	Coffee Cups/Day
Gallstones		Other Drug use:

Release of Patient Information

I verify that the information I have provided in this packet is truthful and correct. I authorize the release of medical information necessary to carry out my treatment, process insurance claims to insurance companies and their agencies, for the purposes of filing and paying medical claims. I authorize payment of medical benefits directly to the medical provider. I acknowledge that interest or a fee may be charged on all past due balances I owe to the provider. I permit a copy of this release to be used in place of the original.

Patient's signature: _____ Date: _____

Release of Information Form

If you would like to share your medical information with another person, please fill out the form below. If you do not designate someone, we cannot discuss your lab, pathology, or radiology results or medications with anyone other than yourself.

Last Name:_____ First Name:_____

Relationship to the patient: _____

Their home phone #:_____ Their cell phone #:_____

Last Name:_____ First Name:_____

Relationship to the patient: _____

Their home phone #:_____ Their cell phone #:_____

Last Name:_____ First Name:_____

Relationship to the patient: _____

Their home phone #:_____ Their cell phone #:_____

I _____ (Patient's name) give permission to the staff of Lawrence Gastroenterology, PA to discuss or release my medical information to the individuals above.

Patient's signature _____ Date: _____