

SHARON R. ROSEMAN, MD

Practice Limited to Gastroenterology

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www.heritagevalley.org/sharonrosemanmd

To All of Our Patients (New and Return)

Registration Packet:

At your first visit, or if you have not been seen for a while, you will be asked to complete a Registration Packet. Due to health care regulations, we are requesting that you complete all forms in their entirety. To facilitate the registration process, please go to www.heritagevalley.org/sharonrosemanmd to complete our Registration Packet and bring it with you. If you are unable to complete your paperwork prior to your appointment, please arrive 20 minutes early. Complete the highlighted areas only of the ***Release of Records Form*** that is enclosed in this packet. This form is used to obtain medical records from other physicians to assist us with your care.

If you are scheduled for a procedure:

- It is important that you return all completed forms to our office **prior** to your appointment date. We need these forms in order to pre-register for your procedure.
- Include a copy of your health insurance card(s).
- Bring all of your medications with you to your procedure.

If you are scheduled for an office visit:

- Complete all forms prior to your appointment date and bring with you to your office visit.
- Bring your health insurance card(s).
- Bring all of your medications with you to your office visit.
- We do not bill for copays. Please bring your copay and/or any outstanding balance you may owe our office.

There will be a fee of \$25.00 for failure to show or late notice cancellations of office visits and a \$55.00 fee for all procedures and new patient office visits. To avoid being charged, please call the office one (1) business day prior to your office visit and two (2) business days prior to your procedure.

Health History

Please answer these questions concerning your health status.
This information will help Dr. Roseman take better care of you.
Of course, all information is confidential

Name _____

Age _____ Date of Birth _____

What is the main reason for today's visit? _____

Family Doctor's Name _____

Health Habits

Please answer each question by checking the appropriate box.
Do you...

Yes No Currently smoke cigarettes?
_____ packs per day _____

Former Smoker Never a smoker

Yes No Chew tobacco?
How much? _____

Yes No Drink beer?
_____ bottles per _____

Yes No Drink wine?
_____ oz. per _____

Yes No Drink hard liquor?
_____ oz. per _____

Yes No Use aspirin, ibuprofen, 'arthritis medications'
How often? _____

Yes No Drink beverages with caffeine
_____ cups per day

Yes No On a special diet
What type? _____

Yes No Do you exercise LESS than twice a week?

Current Medications and Dose NONE (Include all non-prescription medications)

Drug Strength How Often

Allergies to Medications NONE

Operations

What was done? _____ About when? _____ NONE

Do you have a Latex allergy? Yes No
Do you use oxygen? Yes No
Do you have a defibrillator? Yes No

Family Health History

Do these problems run in your family? Please mark an "X" where appropriate.

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Other
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis/ Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Sprue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

06/2016

Name: _____

Date of Birth: _____

Review of Systems

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology

Please check the boxes (yes or no) for each condition mentioned below...

General

- Y N Unexpected weight loss
- Y N Recent weight gain
- Y N Fever or shaking chills
- Y N Night sweats
- Y N Swollen glands
- Y N Take Coumadin, Blood-thinners

Skin

- Y N Severe itching
- Y N Persistent rash
- Y N Changing moles
- Y N Psoriasis

Head

- Y N Severe headaches
- Y N Double vision
- Y N Glaucoma
- Y N Cataracts
- Y N Difficulty hearing
- Y N Ringing in ears
- Y N Wear hearing aid
- Y N Wear dentures
- Y N Loose teeth
- Y N Bleeding gums
- Y N Severe nosebleeds
- Y N Frequent sore throats
- Y N Persistent hoarseness

Blood

- Y N Blood transfusion in past 6 months
- Y N Prolonged bleeding from surgery
- Y N Anemic in past
- Y N Ever treated for cancer
- Y N Think I am at high risk for AIDS

Muscles and Joints

- Y N Muscle cramps
- Y N Muscle weakness
- Y N Arthritis or joint pain
- Y N Frequent back pain

Endocrine

- Y N Thyroid problem
- Y N Diabetes
- Y N Take insulin

Heart and Lungs

- Y N High blood pressure
- Y N High cholesterol
- Y N Heart disease
- Y N Heart attack in past
- Y N Fainting spells
- Y N Irregular heartbeat
- Y N Wear pacemaker
- Y N Have a defibrillator
- Y N Chest pain
- Y N Sleep apnea
- Y N Shortness of breath
- Y N Use oxygen
- Y N Can't breathe when lying flat
- Y N Awaken short of breath
- Y N Ankle swelling
- Y N Heart murmur
- Y N Mitral valve prolapse
- Y N Artificial valve
- Y N Frequent cough
- Y N Cough up sputum
- Y N Cough up blood
- Y N Wheezing or asthma
- Y N Rheumatic fever as child

Digestive Tract

- Y N Poor appetite
- Y N Nausea
- Y N Vomiting
- Y N Frequent heartburn
- Y N Heartburn awakens
- Y N Trouble swallowing
- Y N Hiatal hernia in past
- Y N Rectal bleeding
- Y N Rectal pain
- Y N Black bowel movements
- Y N Vomited blood
- Y N Ulcers in past
- Y N Abdominal pain
- Y N Diarrhea
- Y N Lost bowel movement/soiling
- Y N Constipation
- Y N Bowel habit unpredictable
- Y N Milk or lactose intolerance
- Y N Colon polyps in past
- Y N Colon cancer in past
- Y N Liver disease or jaundice

- Y N Gallstones

Kidneys

- Y N Kidney stones
- Y N Kidney disease
- Y N Frequent urination
- Y N Up nights to urinate
- Y N Blood in urine
- Y N Painful urination
- Y N Slow urination
- Y N Leakage of urine

Brain

- Y N Epilepsy or seizures
- Y N Past strokes

Emotions

- Y N Often depressed
- Y N Cry easily
- Y N Overly anxious
- Y N Can't handle stress

Men only

- Y N Lump in testicles
- Y N Penis discharge
- Y N Erection difficulties

Women only

- Y N Pregnant now
- Y N Planning pregnancy
- Y N Nipple discharge
- Y N Lump in breast
- Y N Vaginal discharge
- Y N Hot flashes
- Y N Non-period bleeding
- Y N Past menopause
- Y N Painful intercourse
- Y N Change in periods
- Y N Past endometriosis

Other Condition(s):

Thank you for completing this questionnaire



PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE
ADDRESS: STREET CITY STATE ZIP SOCIAL SECURITY #: MARITAL STATUS
HOME PHONE # CELL PHONE # DAYTIME PHONE # OCCUPATION CIRCLE ONE
PHARMACY NAME: PHARMACY PHONE # ARE YOU A STUDENT?

RACE (MARK ONE) ETHNICITY (MARK ONE)
American/AK Indian Black/African American Not of Hispanic Origin
Asian/Pacific Islander Hispanic Hispanic Origin
White Unknown/Decline Unknown/Decline

Will the patient be best served in a language other than spoken English? No Yes If yes, please specify:

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN'S NAME:
ADDRESS: STREET CITY STATE ZIP
TELEPHONE # FAX#

INSURANCE INFORMATION **PLEASE HAVE CARDS READY FOR STAFF TO COPY******

NAME OF PRIMARY INSURANCE CO.
INSURED'S NAME (Subscriber of insurance) SUBSCRIBER'S BIRTHDATE
ID # OR AGREEMENT # GROUP #
HOLDER'S RELATIONSHIP TO PATIENT: Check One
Self Spouse Significant Other Natural Child with financial responsibility
Natural Child without financial responsibility Grandchild Other Specify:

EFFECTIVE DATE AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF SECONDARY INSURANCE CO
INSURED'S NAME (Subscriber of insurance) SUBSCRIBER'S BIRTHDATE
ID # OR AGREEMENT # GROUP #
EFFECTIVE DATE:
HOLDER'S RELATIONSHIP TO PATIENT: Check One
Self Spouse Significant Other Natural Child with financial responsibility
Natural Child without financial responsibility Grandchild Other Specify:

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?
You are required to complete an additional form. Automobile Workmen's Comp Other

EMERGENCY CONTACT

PLEASE NAME A PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT THAT WE ARE UNABLE TO REACH YOU.
NAME / RELATIONSHIP: TELEPHONE # - HOME () TELEPHONE # - WORK ()

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Heritage Valley Medical Group/ as noted above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: PATIENT OR RESPONSIBLE PARTY DATE: 06/2012

Please read and sign back page

PATIENT NAME: _____ D.O.B. _____

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

Date Patient Signature HIC #

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

Date Patient Signature HIC #

BLUE SHIELD PATIENTS

We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

COMMERCIAL HEALTH INSURANCE PATIENTS

As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

HMO AND PPO PATIENTS

We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

SELF PAY PATIENTS

Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

Date Patient Signature