BUFFALO-NIAGARA
GASTROENTEROLOGY

New Patient Form

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Please mail attached patient history form and bring your insurance card, and your required copay to the office.

Please contact your doctor's office to obtain your most recent bloodwork, imaging including disks, and office notes. Please ask that they be faxed to our office prior to your appointment date.

If you have seen a Gastroenterologist in the past, we ask that you complete the enclosed release form and send it to our office. This will ensure that we have all required records for your visit.

If your GI records are not obtained at least one week prior to your scheduled appointment with us, your appointment will be rescheduled.

IF THIS IS YOUR FIRST VISIT TO OUR OFFICE, WE ASK THAT YOU ARRIVE 15 MINUTES EARLY. Please make every effort to be on time. If you are 15 minutes late you are at risk off having your appointment rescheduled.

Our office does require 24 hour notice for cancellation. There will be at $50 charge for any missed appointments.

Enclosed please find a copy of our online portal activation letter. This resource enables our practice to communicate directly with our patients while ensuring that all of your medical information is up to date and accurate. If you choose this method of uploading your health information, we do not require you to complete the attached patient history form.

Please do not hesitate to call the office with any questions or concerns

Your appointment is scheduled for _____**with** _____.

Buffalo-Niagara Gastroenterology

Patient History Form

Name_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth___/___/___ Age____ Social Security Number _____

Sex ( )M ( )F Marital Status ( )S ( )M ( )D ( )W Email_____

Race ( )White ( )Black/African American ( )Native American ( )Asian ( )Other_____

Ethnicity ( )Spanish/Hispanic Origin ( )Not of Spanish/Hispanic Origin ( )Unknown/Declined

Employer_____ Phone #_____

Referring Doctor_____ Phone #_____

Primary Care Physician _____ Phone #_____

Person to Notify in Case of Emergency Name_____

Home Phone_____ Cell Phone_____ Relationship_____

Insurance Information

Insured's Name _____ Date of Birth__/__/__ SS#_____

Insured's Employer_____ Phone #_____

Primary Insurance_____ Policy #_____ Group # _____

Relationship to Patient ( )Self ( )Spouse ( )Child ( )Other_____

Pharmacy Information

Pharmacy Name_____ Phone #_____

Pharmacy Address_____

I hereby authorize Buffalo-Niagara Gastroenterology to apply for benefits on my behalf for covered services. I request the payment be made directly to Buffalo-Niagara GI's office. If any insurance does not cover any service, I will be responsible for payment. I certify the above information to be correct. I authorize the release of any medical information necessary to process claims. I permit copy of this authorization to be used in place of the original. In addition, 30% of the balance will be added to any account turned over to a collection agency.

Signature_____ Date___/___/___

Buffalo-Niagara Gastroenterology

Medical History

Past Medical Problems_____

_____

_____

_____

Previous surgeries/Date (including Colonoscopy/EGD)_____

_____

_____

_____

Medications/Vitamins Name/Dosage/Frequency_____

_____

_____

_____

Medication Allergies_____

_____

Smoking History_____ Alcohol_____ Tattoo(s)_____

Intravenous Drug Use_____ Body Piercing(s)_____ Caffeine_____

Buffalo-Niagara Gastroenterology

Family History of Medical Problems

Father_____

Mother_____

Brother(s) _____

Sister(s) _____

Children_____

Maternal Grandmother_____

Maternal Grandfather_____

Paternal Grandmother_____

Paternal Grandfather_____