LONG ISLAND BARIATRIC, PLLC

PATIENT INFORMATION

REFERRED BY:_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

SOCIAL SECURITY #_____-_____-_____DATE OF BIRTH _____/_____/_____ AGE_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated / SEX: ☐ MALE ☐ FEMALE

ADDRESS_____ APT #_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

EMPLOYER NAME: _____ OCCUPATION _____

BUSINESS PHONE: ( ) _____

EMERGENCY CONTACT: _____ RELATIONSHIP_____

HOME PHONE: ( ) _____ WORK/CELL: ( ) _____

PREFERRED LANGUAGE: _____ ETHNICITY: ☐ HISPANIC OR LATINO NON HISPANIC OR LATINO

RACE: ☐ American Indian Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander ☐ Other Race White

PREFERRED COMMUNICATION: Phone Portal Letter No Preference

EMAIL ADDRESS: _____

HEALTH INSURANCE INFORMATION

PLEASE SUBMIT ALL INSURANCE CARDS AND DRIVER'S LICENSE / PHOTO ID FOR SCANNING

PRIMARY INSURANCE COMPANY_____
MEMBER ID_____ GROUP NO._____
POLICY HOLDER INFORMATION: NAME_____
DATE OF BIRTH_____ SOC. SEC. #_____ SEX: ( ) M ( ) F
PATIENT'S RELATION TO INSURED_____

SECONDARY INSURANCE COMPANY_____
MEMBER ID_____ GROUP NO._____
POLICY HOLDER INFORMATION: NAME_____
DATE OF BIRTH_____ SOC. SEC. #_____ SEX: ( ) M ( ) F
PATIENT'S RELATION TO INSURED_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

IF YOU HAVE NO INSURANCE, YOU WILL BE REQUIRED TO PAY AT TIME OF SERVICE.
IF YOUR INSURANCE REQUIRES A REFERRAL AND YOU DO NOT HAVE ONE, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

I HEREBY AUTHORIZE PAAYAL P. MEHTA, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO DR. PAAYAL P. MEHTA, ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE_____ SIGNATURE_____

LONG ISLAND BARIATRIC, PLLC

General Surgery *Bariatric Surgery* *Laparoscopic Surgery* *Breast Surgery*

Paayal P. Mehta, M.D., F.A.C.S

MEDICAL HISTORY

NAME: _____ **DATE:** _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

OCCUPATION: _____

MARITAL STATUS: ___MARRIED __DIVORCED ___ SINGLE ___PARTNERSHIP

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE:_____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

HEADACHES	YES___NO___	STRESS INCONTINENCE	YES___NO___
SHORTNESS OF BREATH	YES___NO___	INDIGESTION/HEARTBURN	YES___NO___
COUGH	YES___NO___	VOMITING	YES___NO___
PALPITATIONS	YES___NO___	ABDOMINAL PAIN	YES___NO___
CHEST PAIN	YES___NO___	BLOOD IN URINE/STOOL	YES___NO___
DIZZINESS	YES___NO___	DIFFICULTY URINATING	YES___NO___
FATIGUE	YES___NO___	PAIN/SWELLING IN LEGS	YES___NO___
CONSTIPATION	YES___NO___	VARICOSE VEINS	YES___NO___
JOINT/MUSCLE PAINS	YES___NO___	DEPRESSION	YES___NO___
ANXIETY	YES___NO___	INSOMNIA	YES___NO___
SNORING	YES___NO___	EXCESSIVE DAYTIME SLEEPINESS	YES___NO___
IMPOTENCE	YES___NO___	FALL ASLEEP INAPPROPRIATELY	YES___NO___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING ILLNESSES/DISEASES?

HEART DISEASE	YES___NO___	DIABETES	YES___NO___
HIGH BLOOD PRESSURE	YES___NO___	HEART ATTACK	YES___NO___
STROKE	YES___NO___	HIGH CHOLESTEROL	YES___NO___
ASTHMA	YES___NO___	EMPHYSEMA/COPD	YES___NO___
DEPRESSION	YES___NO___	CONGESTIVE HEART FAILURE	YES___NO___
ARTHRITIS	YES___NO___	CANCER	YES___NO___
KIDNEY DISEASE	YES___NO___	GLAUCOMA/ EYE PROBLEMS	YES___NO___
SLEEP APNEA	YES___NO___	GALLBLADDER DISEASE	YES___NO___

GASTRO ESOPHAGEAL REFLUX DISEASE (GERD)	YES___NO___	
POLY CYSTIC OVARIAN SYNDROME (PCOS)	YES___NO___	
LUPUS/OTHER COLLAGEN DISEASE	YES___NO___	
ULCER/GASTROINTESTINAL DISEASE	YES___NO___	
THYROID DISEASE	YES___NO___	HYPER OR HYPO *(PLEASE CIRCLE ONE)*

SOCIAL HISTORY:

DO YOU CURRENTLY SMOKE CIGARETTES? YES___NO___ ____#OF CIGARETTES/DAY

IF NO, HAVE YOU EVER SMOKED CIGARETTES IN THE PAST?

YES_____NO_____ _____# OF CIGARETTES/DAY DATE QUIT_____

DO YOU DRINK ALCOHOL? _____NO ____SOCIAL ____OCCASIONAL _____ DAILY

DO YOU HAVE ANY HISTORY OF DRUG OR ALCOHOL ABUSE? YES___NO___

IF YES, PLEASE LIST: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ❑ NO ❑ YES IF YES, PLEASE LIST OR PROVIDE LIST:

MEDICATION	DAILY DOSE	FREQUENCY

ARE YOU ALLERGIC TO ANY MEDICATIONS/FOOD? ❑ NO ❑ YES IF YES, PLEASE LIST:

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR SURGERY? IF YES, PLEASE LIST BEGINNING WITH THE MOST RECENT:

_____

_____

_____

FOR OUR FEMALE PATIENTS:

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____

ARE YOUR MENSTRUAL PERIODS REGULAR? YES___ NO____ AGE OF MENOPAUSE _____

DATE OF LAST PAP_____ DATE OF LAST MAMMOGRAPHY_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____

DO ANY BLOOD RELATIVES HAVE / HAD:

	NO	YES	IF YES, WHO?
CANCER	❑	❑	_____
TUBERCULOSIS	❑	❑	_____
DIABETES	❑	❑	_____
HEART DISEASE	❑	❑	_____
HIGH BLOOD PRESSURE	❑	❑	_____
STROKE	❑	❑	_____
BREAST MASSES OR BREAST TUMORS	❑	❑	_____

LONG ISLAND BARIATRIC, PLLC

715 ROANOKE AVENUE, SUITE 1, RIVERHEAD, NY 11901
240 SILLS ROAD, SUITE 205, EAST PATCHOGUE, NY 11772
Ph: 631-963-4750 Fax: 631-591-1842

Paayal P. Mehta, M.D., F.A.C.S.

We are required by law to maintain the privacy of our patients and provide individuals with our Notice of Privacy Practices with respect to your protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at (631) 963-4750.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Long Island Bariatric, PLLC** to use and/or disclose certain protected health information (PHI) about me to _____.
(name of friend, relative, spouse, etc.)

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____

Date: _____

LONG ISLAND BARIATRIC, PLLC

715 Roanoke Ave, Suite 1, Riverhead, NY 11901
240 Sills Road, Suite 205, East Patchogue, NY 11772
Phone: (631) 963-4750 Fax: (631) 591-1842

Paayal P. Mehta, M.D., F.A.C.S

General Surgery Bariatric Surgery Laparoscopic Surgery Breast Surgery

GUARANTOR AGREEMENT

I. Individual's Responsibility for Non-Covered Services

In consideration of services rendered by Dr. Paayal Mehta to the undersigned patient, the undersigned promise(s) to pay Dr. Paayal Mehta any co-payment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of same prior to the rendering of said services. If a surgical assist is required and the assistant does not participate with my insurance, I will be responsible for fees incurred for the services rendered.

II. Assignment of Benefit Proceeds

I hereby assign to Dr. Paayal Mehta all monies and or/benefits to which I am entitled from my insurer/HMO/third-party payor, government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records

I hereby authorize Dr. Paayal Mehta to release to my insurer/HMO/third-party payor, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services that are improperly billed.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

_____ _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF DR. PAAYAL MEHTA

DATE

LONG ISLAND BARIATRIC, PLLC

715 ROANOKE AVENUE, SUITE 1, RIVERHEAD, NY 11901
240 SILLS ROAD, SUITE 205, EAST PATCHOGUE, NY 11772

Paayal P. Mehta, M.D., F.A.C.S.

Attention: Patients of Long Island Bariatric, PLLC

RE: Fee for missed appointments and appointments not cancelled 24 hours in advance

If you are a patient of Long Island Bariatric, PLLC and you ***cannot keep your appointment***, ***you must notify the office 24 hours prior to the day you are scheduled***.

Patients that fail to show up for their appointments that are scheduled with Deborah L. Sforza, R.D., CDN, Christina Harrington, R.D., or Iris Pappalardo, R.N., LCSW-R without notifying the office 24 hours in advance will be charged a fee of $50.00.

Patients that fail to show up for an appointment scheduled with Dr. Paayal Mehta without notifying the office 24 hours in advance will be charged a fee of $25.00.

Patients that cancel their appointment ***at least 24 hours before the day*** of their appointment will not be charged any fee.

Missed appointments without calling the office wastes time, is inefficient, and denies our other patients the ability to schedule their appointments on those days.

In order for our office to provide the best care and services possible, we need the help and cooperation of our patients. Let us all work together.

Thank you for you cooperation.

Signature: _____

Date:_____