MAIN STREET MEDICAL SERVICES PLLC
GASTROENTEROLOGY

55-16 Main Street
Flushing, New York, 11355
718.461.6161 • Fax: 718.461.3590

David J. Beyda, MD
Sherli Payamipour, RPAC

Date: ____/____/____

Last Name: ____ **First Name**: ____

Circle one: Male or Female **Social Security #**: XXX – XX - _______

Date of Birth: ____/____/_____ **Age** ______ **Email Address**: ____

Address:____

Street Apt City State Zip

Home Phone #: (____) ______________________ **Cell Phone #**: (____) ________________________

Employer: ____ **Phone**: _________________________________

Address: ____ **Occupation**: ____________________________

Name of Emergency Contact: ____

Relationship: ____ **Phone**: ____

Pharmacy Name: ________________________________ **Pharmacy Phone**: ______________________________________

My signature below acknowledges the following:

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.
- I have received information on/am aware of the **Speak Up Program** Campaign.

Signature of Patient/ Representative_________________________________ **Date**_______________

Above signature was not obtained because:

□ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.

□ Patient refused to sign □ Patient refused forms

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, private insurance and any other health plan to Main Street Medical Services, PLLC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as original. I understand that I am financially responsible for all charged whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Signed:____ **Date:**_________________

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Your Name: ______________________________ Date: _____________________

1. What is the reason for your visit today?

   ____

2. Who is your referring physician (First and Last Name) ?

   ____

3. Do you have any medical conditions? YES or NO (if yes please list)

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

4. Have you ever had any surgeries in the past? YES or NO (if yes please list)

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

5. Do you take any medications? YES or NO (if yes please list)

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

6. Are you **allergic** to any medications? YES or NO (if yes please list)

   ____

7. Do you smoke? YES or NO
   A. If you answered Yes how much do you smoke? ________________________

8. Do you drink alcoholic beverages? YES or NO
   A. If you answered Yes how often do you drink? ________________________

9. Do you have any family history for any illnesses? YES or NO (if yes please list)

1) ______________________________ 2) ______________________________

10. Do you have any family history of cancer? YES or NO (if yes please list)

1) ______________________________ 2) ______________________________

11. Have you ever had a colonoscopy? YES or NO
    A. If you answered Yes when was your last colonoscopy and what were the findings at that time? ____

12. Have you had a complete blood test in the past year? YES or NO

13. If you were born during **1945-1965**, have you ever been tested for Hepatitis C? YES or NO
    Would you like to be tested today? YES or NO

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Do you have a history of any of the following?

Check all that apply

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Gastrointestinal:

Upper GI:

□ Stomach ulcers	□ Heart burn	□ Nausea/Vomiting
□ Difficulty swallowing	□ Painful swallowing	□ Weight gain ___lbs
□ Weight loss___lbs	□ Bloating	□ Other___________________

Lower GI:

□ Constipation	□ Diarrhea	□ Pain with bowel movement
□ Hemorrhoids	□ Excessive gas	□ Black stools
□ Rectal pain	□ Rectal bleeding	□ Rectal itching
□ Colon polyps	□ Colon cancer	□ Family history of colon cancer
□ Other_______________		Specify___________________

Liver:

□ Yellow eyes/skin (Jaundice)	□ Cirrhosis	□ Hepatitis

Gallbladder & Pancreas

□ Gallstones	□ Gallbladder surgery	□ Pancreatitis

General:

□ Fevers	□ Night sweats	□ Fatigue

Skin:

□ Rashes	□ Sores	□ Skin cancer

Endocrine:

□ Thyroid problems	□ Abnormal tolerance to hot or cold	□ Diabetes

Eyes:

□ Yellowing of eyes	□ Discharge	□ Other__________

HEENT:

□ Frequent nose bleeds	□ Change in voice	□ Other__________

Heart:

□ Murmur	□ Palpations	□ Heart attack
□ Angina	□ Congestive heart failure	□ High blood pressure
□ Cardiac stent	□ Cardiac surgery	□ Other___________________

Lungs:

□ Asthma	□ COPD	□ Lung cancer

Genitourinary:

□ Burning with urination	□ Pain with urination	□ Blood in urine

Musculoskeletal:

□ New joint pain	□ New back pain	□ Arthritis

Infectious:

□ Recent infection

Specify___________________________________