SHARON R. ROSEMAN, MD
Practice Limited to Gastroenterology
701 Broad Street, Suite 411
Sewickley, PA 15143
(412)749-7160 • Fax (412)749-7388
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

Name

What is the main reason for today's visit?

Health Habits
Please answer each question by checking the appropriate box.

Do you...

☐ Yes ☐ No  Currently smoke cigarettes?  _packs per day_

☐ Yes ☐ No  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?  

Operations
What was done?  ☐ NONE  

About when? 

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

Drug  Strength  How Often

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

Allergies to Medications  ☐ NONE

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

☐ Yes ☐ No  _____________________________________________________________________

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.

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<tr>
<th>Problem</th>
<th>Father</th>
<th>Mother</th>
<th>Father’s Father</th>
<th>Mother’s Mother</th>
<th>Brothers</th>
<th>Sisters</th>
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06/2016

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology
# Review of Systems

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

## 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.

[Heritage Valley Medical Group Logo]
PATIENT INFORMATION

NAME: FINAL FIRST MIDDLE INITIAL SEX BIRTHDATE

ADDRESS: STREET CITY STATE ZIP SOCIAL SECURITY #: MARITAL STATUS

HOME PHONE # CELL PHONE # DAYTIME PHONE # OCCUPATION CIRCLE ONE

( ) ( ) ( ) FT PT RET Not Employed

PHARMACY NAME: PHARMACY PHONE # ARE YOU A STUDENT?

( ) Yes No Part time Full time

RACE (MARK ONE)
☐ American/AK Indian ☐ Black/African American
☐ Asian/Pacific Islander ☐ Hispanic
☐ White ☐ Unknown/Decline

ETNICITY (MARK ONE)
☐ Not of Hispanic Origin
☐ Hispanic Origin
☐ 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 #

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

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT? ☐ No ☐ Yes

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:

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
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 06/2012