# PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ Age: _____ Sex: ❑Male ❑Female
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Mailing Address (if different): _____
Home Phone: _____ Work Phone: _____
Cellular Phone:_____ E-mail:_____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: _____ Driver's License #: _____
Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Race: ❑American Indian or Alaska Native ❑Asian ❑ Black or African American
❑Native Hawaiian or other Pacific Islander ❑ White ❑Other Race
Ethnicity: ❑ Hispanic or Latino ❑Non-Hispanic or Non-Latino

## INSURANCE INFORMATION

Primary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: Subscriber DOB:

## GUARANTOR INFORMATION

**Please complete this section if someone other than the patient is guarantor of payment.**
Guarantor's Name (❑spouse, ❑parent or ❑guardian): _____
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: Driver's License #:

## OTHER IMPORTANT INFORMATION

**Contacts:**
**Spouse**: Name _____ Cell Phone _____ Work Phone _____
**Emergency Contact:** Person to contact in an emergency (someone not living with you):
Last Name _____ First Name _____ Relationship _____
Home Phone # _____ Cell Phone #_____
**Pharmacy:** Name & City _____ Phone _____
**Referring MD:** _____**Primary Care Physician:** _____
**How did you hear about us?** ❑Referred by Physician (Name: _____)
❑I am existing Patient ❑Referred by Friend or Family Member (Name:_____)
❑Listed in Insurance Plan Roster ❑Internet : Name of the website: _____
❑Phone Book ❑Other (please specify): _____

Signature of Patient/Guardian:_____ Date: _____

# PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

## PRIVACY PRACTICES NOTICE AND ACKNOWLEDGEMENT

Last Name _____ First Name _____ Date of Birth _____

**Privacy Notice**: This notice describes how your medical information may be used and disclosed for the purposes of treatment, payment, and healthcare operations, and how you can access this information. This explains your rights and our obligations under the law. This notice may be revised from time to time.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This is also available online at www.PacificGastro.com .

**Acknowledgement:** I acknowledge that I have been provided an opportunity to review and receive the notice of privacy practices.

### RELEASE OF INFORMATION

☐ I authorize the release of my protected health information (PHI) to the following individual(s):

- ☐ Spouse: Name _____
- ☐ Child(ren): Name(s) _____
- ☐ Other: Name and relationship _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

### MESSAGES

Please call: ☐ First preference Phone # _____

☐ Second preference Phone # _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signature of Patient/Guardian _____ Date _____

# PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
# **FINANCIAL POLICY**

| **PATIENT INFORMATION** | | |
|---|---|---|
| Name: | Date of Birth: | Today's date: |

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

***Regarding Insurance:***
As a courtesy, our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time during treatment**. Please understand that your bill is ultimately YOUR responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. You will be charged a $25 fee for any returned check. Any account over 90 days old without payment is subject to being sent to a collection agency.

**We strongly encourage you to personally contact your insurance company about your co-pay, co-insurance and deductibles. You must understand what your insurance benefits cover and how this may affect you financially**.

***Co-pay, Deductible and Co-insurance:***
Your insurance Co-pay, unmet deductible and estimated co-insurance amounts are due **prior** to service. **Failure to pay may lead to rescheduling or cancellation of appointment.**

***Payment Methods:***
We accept Cash, Check, Credit cards (Visa, MasterCard, and Discover), Apple pay, Android Pay and Samsung Pay.

***Referrals and Pre-authorization:***
If your insurance company requires a referral/prior authorization from your primary care physician, you must present this referral to our staff before being seen. If you do not obtain a referral when your insurance company requires one, you will be required to pay in full for the visit or service. It is YOUR responsibility to make sure a referral has been obtained for any procedures as well.

***Missed Appointments and Cancellation Fee:***
Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 3 working days notice for cancellation of any procedures. **It is our policy to charge a $100.00 cancellation fee if given less than 3 working days notice.** The charge for a late cancellation/no show for procedure will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

***Ancillary Services:***
Please be aware that there may be a charge involved for ancillary services such as completing disability forms and/or forms related to your care, and drafting letters on your behalf. A $10 copying and handling fee is charged for providing medical records to you.

***Patient Balances/Late Fee:***
If payment is not received within 30 days of the statement, a $20.00 late fee each month may be applied to your balance until full payment is received.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I authorize Pacific Gastroenterology Medical Associates, Inc. or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the physician.

I have read the Financial Policy in full and I understand and agree to this policy.

_____ _____

Signature of Patient/Guardian Date

# PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
# HEALTH QUESTIONNAIRE

| **PATIENT INFORMATION** | | |
|---|---|---|
| Name: | Date of Birth: | Current Age: |
| Today's date: | Referring physician: | |

**Reason of Visit/Chief Complaint:**

| **MEDICAL HISTORY –** PAST OR PRESENT ILLNESS | | | | |
|---|---|---|---|---|
| **Gastrointestinal system:** | | | | |
| ☐ Acid Reflux/GERD | ☐ Peptic ulcer | ☐ Helicobacter pylori | ☐ Barrett's esophagus | ☐ Celiac disease |
| ☐ Ulcerative colitis | ☐ Crohn's disease | ☐ Diverticulosis of colon | ☐ Irritable bowel (IBS) | ☐ Hemorrhoids |
| ☐ Colon Polyp | ☐ Colon cancer | ☐ Esophageal cancer | ☐ Stomach cancer | ☐ Liver cancer |
| ☐ Hepatitis A | ☐ Hepatitis B | ☐ Hepatitis C | ☐ Fatty liver | ☐ Cirrhosis of liver |
| ☐ Gall stones | ☐ Pancreatitis | ☐ Alcoholism | ☐ Eating disorder | ☐ Lactose intolerance |
| **Other systems:** | | | | |
| ☐ High blood pressure | ☐ Heart artery disease | ☐ Irregular heart rhythm | ☐ Heart failure | ☐ Heart attack (MI) |
| ☐ Heart murmur | ☐ COPD/Emphysema | ☐ Asthma | ☐ Sleep apnea | ☐ Pulmonary embolism |
| ☐ High cholesterol/Lipid | ☐ Bleeding disorder | ☐ Anticoagulant therapy | ☐ Anemia | ☐ Deep venous clots |
| ☐ Diabetes mellitus | ☐ Pre-diabetes | ☐ Hypothyroidism | ☐ Kidney disease | ☐ Kidney stones |
| ☐ Osteoporosis | ☐ Osteopenia | ☐ Osteoarthritis | ☐ Rheumatoid arthritis | ☐ Spine/disc disease |
| ☐ Migraine | ☐ Anxiety | ☐ Depression | ☐ Bipolar disorder | ☐ Schizophrenia |
| ☐ Seizures | ☐ Stroke | ☐ Parkinson's disease | ☐ HIV/AIDS | ☐ TB/Positive PPD |
| ☐ Basal cell skin cancer | ☐Squamous skin cancer | ☐ Melanoma | ☐ Glaucoma | ☐ Gout |
| **List other Illnesses:** | | | | |
| | | | | |
| | | | | |

| **PREVIOUS GASTROINTESTINAL PROCEDURES** ☐ No GI Procedures | | | |
|---|---|---|---|
| **Procedure** | **Date(s)** | **Procedure** | **Date(s)** |
| ☐ Colonoscopy | | ☐ Upper GI Endoscopy/EGD | |
| ☐ Sigmoidoscopy | | ☐ Other | |

| **PREVIOUS SURGERIES** ☐ No Surgeries | | | |
|---|---|---|---|
| **Surgery** | **Date(s)** | **Surgery** | **Date(s)** |
| ☐ Appendectomy | | ☐ Gall bladder removal | |
| ☐ Gastric bypass | | ☐ Laparoscopy | |
| ☐ Colon resection | | ☐ Exploratory, abdomen | |
| ☐ Hemorrhoid surgery | | ☐ Hernia repair, groin | |
| ☐ Heart bypass surgery | | ☐ Heart stent(s) | |
| ☐ Heart pacemaker | | ☐ AICD/defibrillator | |
| ☐ Artificial heart valve | | ☐ Tonsillectomy | |
| ☐ Hip Replacement : ☐ Left ☐ Right | | ☐ Knee replacement: ☐ Left ☐ Right | |
| ☐ Hysterectomy: ☐Partial ☐Complete | | ☐ Caesarean section | |
| ☐ Tubal ligation | | ☐ Mastectomy: ☐ Left ☐ Right | |
| ☐ Lasik eye surgery | | ☐ Cataract: ☐ Left ☐ Right | |
| **List other Surgeries and their dates:** | | | |
| | | | |
| | | | |

| **IMMUNIZATION HISTORY** | |
|---|---|
| ☐ Hepatitis B vaccination , when: | ☐ Hepatitis A vaccination, when: |

| **SOCIAL HISTORY** |
|---|
| **Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil union ☐ Other |
| **Occupation:** ☐ Retired ☐ Disabled **Children:** ☐ No ☐ Yes Number: |
| **Tobacco Smoking:** ☐ Never smoked ☐ Quit smoking, When: _____ ☐ Number of Years smoked _____ |
| ☐ Current smoker: ☐ Daily ☐ Someday Number of cigarettes per day: ☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more |
| **Alcohol:** ☐ None ☐ Quit, When: _____ ☐ Current # of drinks on a typical day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more |
| Frequency: ☐ 4 or more days/week ☐ 2-3 days/week ☐ 2-4 days/month ☐ Monthly or less |
| **Caffeine:** ☐ None ☐ Coffee: _____ cups/day ☐ Tea: _____ cups/day ☐ Soda: _____ drinks/day: |
| **Recreational Drug use:** ☐ Never ☐ Quit using ☐ Currently using; DRUG: ☐ Marijuana ☐ Cocaine ☐ Other _____ |
| **Blood transfusion:** ☐ No ☐ Yes, When: **Tattoo:** ☐ No ☐ Yes **Acupuncture:** ☐ No ☐ Yes |

| Patient Name: | Date of Birth: |
|---|---|

**FAMILY HISTORY** ☐ Unknown ☐ Adopted

| Relative | Alive (A) or Dead (D) | Colon Cancer | Esophagus Cancer | Stomach Cancer | Liver Cancer | Pancreas Cancer | Ulcerative Colitis | Crohn's Disease | Other Disease(s) |
|---|---|---|---|---|---|---|---|---|---|
| Father | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Mother | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Brother | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Sister | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Son | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Daughter | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Paternal grandmother | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Paternal grandfather | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Maternal grandmother | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Maternal grandfather | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Uncle | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Aunt | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Nephew | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Niece | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Cousin | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

**No known Family history of**: ☐ Colon cancer ☐ Esophageal cancer ☐ Stomach cancer ☐ Liver cancer ☐ Pancreas cancer ☐ Crohn's disease ☐ Ulcerative colitis

**Any comment / relevant Family history:**

**REVIEW OF SYSTEMS:** Please check appropriate boxes if you **currently** have any of these symptoms.

| | | | | |
|---|---|---|---|---|
| **General/Constitutional:** | | | | |
| ☐ Fever | ☐ Tired/fatigue | ☐ Loss of appetite | ☐ Recent weight loss | ☐ Recent weight gain |
| **Gastrointestinal system:** | | | | |
| ☐ Abdominal pain | ☐ Diarrhea | ☐ Constipation | ☐ Bowel habit change | ☐ Stool caliber change |
| ☐ Rectal bleeding | ☐ Black tarry stool | ☐ Fecal incontinence | ☐ Anal/rectal pain | ☐ Anal itch |
| ☐ Heartburn | ☐ Acid regurgitation | ☐ Excessive burping | ☐ Nausea | ☐ Vomiting |
| ☐ Difficulty swallowing | ☐ Painful swallowing | ☐ Vomiting blood | ☐ Abdominal bloating | ☐ Flatulence/gaseous |
| **Cardiovascular:** | | | | |
| ☐ Chest pain | ☐ Shortness of breath | ☐ Dizziness/fainting | ☐ Palpitations | ☐ Ankle swelling |
| **Respiratory:** | | | | |
| ☐ Cough | ☐ Wheezing | ☐ Coughing up blood | ☐ Sleep apnea | |
| **Eyes/ENT:** | | | | |
| ☐ Blurred vision | ☐ Loss of vision | ☐ Sore throat | ☐ Hoarse voice | ☐ Nose bleeding |
| **Genitourinary/Kidneys:** | | | | |
| ☐ Frequent urination | ☐ Blood in urine | ☐ Dark urine | ☐ Urethral discharge | ☐ Impotence |
| **Endocrine:** | | | | |
| ☐ Heat intolerance | ☐ Cold intolerance | ☐ Excessive thirst | ☐ Excessive hair loss | |
| **Hematologic/Lymphatic:** | | | | |
| ☐ Bleeding gums | ☐ Excessive bruising | ☐ Prolonged bleeding | ☐ Swollen glands/nodes | |
| **Musculoskeletal:** | | | | |
| ☐ Joint pain | ☐ Joint swelling | ☐ Joint stiffness | ☐ Lower back pain | ☐ Neck pain |
| **Neurological:** | | | | |
| ☐ Headache | ☐ Fainting | ☐ Tingling/numbness | ☐ Paralysis of limb(s) | ☐ Seizures |
| **Psychiatric:** | | | | |
| ☐ Difficulty sleeping | ☐ Excessive stress | ☐ Panic attacks | ☐ Suicidal thoughts | ☐ Hallucination |
| **Skin:** | | | | |
| ☐ Rash | ☐ Itching | ☐ Hives | ☐ Jaundice | ☐ Skin lesions |
| **Female patients only:** | | | | |
| ☐ Abnormal menses | ☐ Menopause | ☐ Oral contraceptive | ☐ Currently pregnant | ☐ Vaginal bleeding |

**ADDITIONAL COMMENTS:**

Signature of Patient/Guardian

Date

PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

# MEDICATIONS & ALLERGY FORM

| **PATIENT INFORMATION** | | |
|---|---|---|
| Name: | Date of Birth: | Current Age: |
| Today's date: | Pharmacy: | |

☐ **See Attached Medication List**

| **PRESCRIPTION MEDICATIONS -** CURRENTLY USING | | | ☐ Not taking any prescription medication | |
|---|---|---|---|---|
| **Medications** | **Dose (How much?)** | **Route (How taken?)** | **Frequency (How often?)** | **Indication (What for?)** |
| *Example: Nexium* | *40 mg capsule* | *Orally* | *Once a day* | *Acid reflux* |
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| **Additional comment:** | | | | |
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| **OVER THE COUNTER (OTC) MEDICATION/SUPPLEMENT -** CURRENTLY USING | | | ☐ Not taking any OTC medication | |
|---|---|---|---|---|
| **Medications** | **Dose (How much?)** | **Route (How taken?)** | **Frequency (How often?)** | **Indication (What for?)** |
| *Example: Advil* | *200 mg tablet* | *Orally* | *As needed* | *Joint pain* |
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| **Additional comment:** | | | | |
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| **DRUG ALLERGY** | | | ☐ No known drug allergy |
|---|---|---|---|
| **Medications** | **Type of reaction** | **Medications** | **Type of reaction** |
| *Example: Penicillin* | *Rash* | | |
| ☐ Sulfa | | | |
| ☐ Erythromycin | | | |
| ☐ Penicillin | | | |
| ☐ Latex | | | |
| ☐ Tape | | | |
| ☐ IV contrast | | | |
| ☐ Demerol | | | |
| ☐ Versed | | | |
| **Additional comment:** | | | |
| | | | |
| | | | |

_____ _____

Signature of Patient/Guardian Date