2900 Whipple Ave. suite 245
Redwood City, CA 94062
(650) 365-3700
(650) 368-3836

James Torosis, MD
Vicky Yang, MD
Daniel Rengstorff, MD
Cynthia Leung, MD
Carmen Lim, MD

Patient Interview Form

Patient Information

First Name:__________________ Last Name:__________________

Date Of Birth:__________________ Age:__________________

Notes:__________________

Email

Please check one as your preferred email for communications

- ◯ Personal:__________________
- ◯ Work:__________________

Race

Select one or more

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ Chinese
- ◯ English
- ◯ French
- ◯ Spanish; Castilian
- ◯ Tagalog
- ◯ Patient declines to specify

Contact Preference

- ◯ Home #
- ◯ Cell #
- ◯ Work #
- ◯ Patient declines to specify
- Other:__________

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Latex
- ◯ Penicillins
- Other:__________
- Other:__________
- Other:__________

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep A, adult When:______

☐ Hep B, adult When:______

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:______

☐ Endoscopy When:______

☐ Sigmoidoscopy When:______

☐ Abdominal Ultrasound When:______

☐ CT Abdomen When:______

☐ MRI When:______

Other:______

Past or Present Medical Conditions

☐ None

GASTROINTESTINAL: ☐ Acid Reflux ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon cancer ☐ Colon polyps ☐ Diverticulitis/Diverticulosis ☐ Gastric Ulcer ☐ Gastritis ☐ Hepatitis B ☐ IBS ☐ Cirrhosis ☐ Hepatitis C

CARDIOVASCULAR: ☐ Arrhythmia ☐ Congestive Heart Failure ☐ High blood pressure ☐ Heart Attack ☐ Hyperlipidemia

PULMONARY: ☐ Asthma ☐ C.O.P.D. ☐ Sleep Apnea w/CPAP

MUSCULOSKELETAL: ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Spine Disease

ENDOCRINE: ☐ Diabetes Mellitus ☐ Thyroid Disorder

HEMATOLOGICAL: ☐ Anemia ☐ Bleeding Problems

NEUROPSYCHIATRIC: ☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Parkinson's ☐ Seizures ☐ Stroke or Paralysis

OTHER: Other:______ Other:______ Other:______

Previous Procedures

- None
- Appendectomy — When: ____
- Joint Replacement — When: ____
- Colon Resection — When: ____
- Gastric By-Pass — When: ____
- Mastectomy — When: ____
- Open Heart Surgery- — When: ____
- Pace Maker placement — When: ____
- Coronary stent placed — When: ____
- AICD or internal defibrillator — When: ____
- Gallbladder removed — When: ____
- Hysterectomy — When: ____

Other: ____ Other: ____ Other: ____ Other: ____ Other: ____

Other: ____ Other: ____ Other: ____ Other: ____ Other: ____

Social History

Occupation: ____ Number of Children: ____

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Other

Alcohol

- None

Type	Number	Frequency
Beer		
Wine		
Liquor or Spirits		

Caffeine

- None
- Coffee
- Soda
- Tea
- Energy Drinks
- Less than 2 per day
- 2-5 per day
- More than 5 per day

Intake: ____

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Type	Started

Drug Use

- None
- Marijuana
- Intravenous Drugs/Illicit drugs

Type: ____

Exercise

- None

Type	Quantity	Frequency
Yes		

Family Medical History

○ No knowledge of family history

No family history of ○ Autoimmune Disease ○ Bleeding/Clotting ○ GI Disorders ○ GI malignancies ○ Liver Disease

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Colon Polyps	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
shortness of breath when lying down	○	○
palpitations	○	○
swelling of legs	○	○
passing out	○	○

Constitutional

None	Y	N
tired	○	○
fever	○	○
loss of appetite	○	○
tired or fatigued	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
sores in mouth	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
light hurts eyes	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
swallowing problems	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
hemorrhoids	○	○
rectal pain	○	○
burping	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
waking up in night to urinate	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Pharmacy

Name | Address | Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

○ Yes ○ No

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature | Date

Peninsula Gastroenterology Medical Group

James D. Torosis, MD, FACP
Vicky W. Yang, MD
Daniel Rengstorff, MD
Cynthia Leung, MD

Gastroenterology & Hepatology

Patient Information

Who referred you to this office?_____________________ Primary Care Physician_________________________

First Name__________________________ Last Name________________________ Middle Initial___________

Date of Birth ______/_____/_______ ☐ Male ☐ Female Marital Status (circle one) S / M / W / D / DP

Spouse Name_____________________________________

Address (street address) ____ Unit#_____________________

City____________________________________State___________Zip Code_________________________1st Call Phone Number___________________(H/W/C) 2nd Call Phone Number___________________(H/W/C)

Email Address:_______________________________

Employer Name______________________________ Occupation/Title________________________________

EMERGENCY CONTACT INFORMATION

Name___________________________Relation__________________________Phone________________

INSURANCE INFORMATION

Primary SUBSCRIBER NAME:_____________________________SUBSCRIBER DOB: _________________

SUBSCRIBER ID: ____________________________________

INSURANCE PLAN (i.e. Blue Cross, Blue Shield, Aetna, etc.): ____

Address (street address) ____

City____________________________________State___________Zip Code________________________

PLAN TYPE: ☐ PPO ☐ HMO ***HMO NETWORK:** ☐ SPN ☐ SCCIPA ☐ Direct Network SM

☐ POS ☐ MED

I request that payment of authorized insurance benefits be made to (the physician/supplier) for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim; if at the time of your service, you state you have had valid insurance coverage, but late determine, for whatever reason, you were not covered, you acknowledge and agree that you are responsible for the entire fee. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as coinsurance and the deductible are based upon the charge determination of the Medicare carrier. My signature authorizes releasing of the information to the insurance or agency shown.

____ _________________________

Signature of Patient **Date**

PENINSULA GI MEDICAL GROUP
OUR FINANCIAL POLICY

Thank you for choosing **Peninsula GI Medical Group** 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.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

**All Patients must complete a Patient Information Form before seeing the doctor.

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 within 45 business days, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and Master Card. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

**All co-pays are due at the time of treatment.

*****We DO NOT accept any Blue Cross Covered California or Health Net Covered California plans. If you have Blue Cross or Health Net insurance, it is your responsibility to know if it is through Covered California. If this is realized after your visit, you will be responsible for the entire cost of the visit.**

Missed Appointments:
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 $300.00 cancellation fee if given less than 72 hours notice. We will waive this fee if we are able to fill your procedure time; however, there is no guarantee that we will be able to do that in such a short amount of time.** If you are scheduled for an office appointment, we must receive a notice of cancellation at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. The charge for a late cancellation/no show procedure or appointment 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 multiple telephone calls, extended telephone conversations, completing disability forms and/or forms related to your care, and drafting letters on your behalf.

Patient Balances:
If payment is not received within 30 days of the statement, a late fee will be applied to your balance as follows:

- Patient Balances of $0.01-$500.00 will incur a $10.00 late fee each month until payment is received
- Patient Balances greater than $500.00 will incur a $25.00 late fee each month until payment is received

Thank you for taking the time to review our Financial Policy. Please let us know if you have questions or concerns.

I have read and understand the Financial Policy in full.

____
Printed Name of Patient

________________________________ _______________________
Signature of Patient Date Signed

Acknowledgment of Receipt of Notice of Privacy Practices

Peninsula Gastroenterology Medical Group
2900 Whipple Avenue Suite 245, Redwood City, CA 94062
Privacy Officer Telephone Number 650-365-3700

I hereby acknowledge that I received or reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the patient waiting area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I authorize Peninsula Gastroenterology Medical Group to discuss my medical treatment with the following (i.e. spouse, friend, children. There is no need to list referring physicians):

NAME OF PERSON	RELATIONSHIP TO PATIENT
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Print **Your** Name: ______________________________________

Telephone: ______________________________________

Signature: ____ Date: ____________________

If not signed by the patient, please indicate relationship below:

- ○ Parent or Guardian of Minor Patient
- ○ Guardian or Conservator of an incompetent Patient
- ○ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________________