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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)

3rd Call Phone Number _____ (H/W/C) Email Address: _____

Employer Name _____ Occupation/Title _____

*** Is it okay to leave messages regarding your treatment on your first call phone number? Yes No

***** If **NO** can we leave a message on the second number above? Yes No

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.): _____

PLAN TYPE: PPO HMO ***HMO NETWORK:** SPN PAMF Direct Network SM
 POS MED

PRE-CERTIFICATION PHONE NUMBER: _____

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 later 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 Gastroenterology Medical Group

Patient Health Questionnaire

Please fill out as much information as possible to help with your medical care. Use the back of the sheet if you run out of space. For medications please include dosing (how many, milligrams etc).

Date: _____ Patient Name: _____

Date of Birth: ____/____/____ Marital Status: S / M / D / DP

Referring/Primary Provider: _____

Why are we seeing you today? _____

Past Medical Problems/Illnesses (Examples: Diabetes, high blood pressure)

Past Surgeries (Examples: Heart bypass, appendectomy, prior sedation/anesthesia etc)

Medication Allergies

<u>Drug</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Current Medications, Vitamins and Supplements List

<u>Medication Name</u>	<u>Dose</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

<u>Any stomach, liver disease or cancer</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

Social History

Occupation: _____

Do you Drink Alcohol? Yes / No **If yes, how many drinks per week? _____

Do you Smoke? Yes / No **If yes, how many packs per week? _____

Do you Drink Caffeine? Yes / No **If yes, how many drinks per week? _____

Do you use or have you ever used Marijuana and/or intravenous or illicit drugs? Yes / No

**If yes, what and when? _____

NAME: _____ DATE: _____

Review of Systems: Please **circle** any symptoms that you have **currently** and **check** those that you have suffered from in the past. ○ = current /

GENERAL:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue/Weakness | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Night Sweats | |

GASTROINTESTINAL:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Painful defecation | <input type="checkbox"/> Hepatitis |

CARDIOVASCULAR:

- | | | |
|---|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Swelling in legs | <input type="checkbox"/> Pain in legs with walking | |

PULMONARY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> TB | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Chronic sore throat |

SKIN:

- | | | |
|-------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> Jaundice |
|-------------------------------|----------------------------------|-----------------------------------|

MUSCULOSKELETAL:

- | | | |
|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Joint pains/swelling | <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Sciatica | | |

EARS, NOSE and THROAT:

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sores in mouth |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Ringing in ears |

HEMATOLOGICAL:

- | | |
|--|--|
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Bleeding problems |
|--|--|

PSYCHIATRIC:

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Abnormal sleep | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Suicide Attempts | |

NEUROLOGICAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic numbness/tingling | <input type="checkbox"/> Extremity weakness | <input type="checkbox"/> Stroke or paralysis |

Other symptoms:

PENINSULA GI MEDICAL GROUP
OUR FINANCIAL POLICY
Beginning January 2010

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.

****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.

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

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. 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.

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.

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

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

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: _____