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Redwood City, CA 94062
(650) 365-3700
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James Torosis, MD
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Daniel Rengstorff, MD
Cynthia Leung, MD
Virginia Morrow, MSN, ANP

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Notes:_____

Race

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Mixed
- ☐ Other
- ☐ Unknown
- ☐ Patient declines to provide information

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information

Gender

- ☐ Male
- ☐ Female
- ☐ Other

Preferred Language

- ☐ English
- ☐ Chinese
- ☐ French
- ☐ Spanish
- Other:_____

Contact Preference

- ☐ Home #
- ☐ Cell #
- ☐ Work #
- 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?

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:_____

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 ☐ 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 GI malignancies

GI/Liver, bleeding/clotting, or autoimmune disease

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

Review Of Systems

	Yes	No
Allergic/Immunologic		
None		
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○
Cardiovascular		
None		
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
shortness of breath when lying down	○	○
palpitations	○	○
swelling of legs	○	○
passing out	○	○
Constitutional		
None		
tired	○	○
fever	○	○
loss of appetite	○	○
tired or fatigued	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○
ENMT		
None		
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
sores in mouth	○	○
Endocrine		
None		
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

	Yes	No
Eyes		
None		
double vision	○	○
loss of vision	○	○
light hurts eyes	○	○
Gastrointestinal		
None		
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
swallowing problems	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
hemorrhoids	○	○
rectal pain	○	○
Genitourinary		
None		
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		
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

	Yes	No
Integumentary		
None		
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○
Musculoskeletal		
None		
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○
Neurological		
None		
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
Psychiatric		
None		
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○
Respiratory		
None		
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Pharmacy

Name:_____

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

_____

Signature Date

James Torosis, MD, FACP
Vicky Yang, MD
Daniel Rengstorff, MD
Cynthia Leung, MD
Virginia Morrow, MSN, ANP

PGI

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 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.

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

Amended 07.2013

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: _____