Peninsula Gastroenterology Medical Group

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Redwood City, CA 94062
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(650) 368-3836

James Torosis, MD
Vicky Yang, MD
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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:_____

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
- ○ GI Disorders
- ○ Liver Disease
- ○ Bleeding/Clotting
- ○ GI malignancies

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
Gastroenterology & Hepatology

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PATIENT INFORMATION & DEMOGRAPHICS

How did you hear about us? MD Referral | Web Search | Other _____

First Name _____ Last Name _____

Date of Birth ____/____/____ Gender _____ Marital Status S | M | W | D | DP

Street Address _____ Unit _____

City _____ State _____ ZIP Code _____

1º Phone _____ H | W | C 2º Phone _____ H | W | C

Email _____ Primary Care Physician _____

Employer _____ Occupation/Title _____

EMERGENCY CONTACT

Name _____ Relation _____ Phone _____

INSURANCE INFORMATION

Subscriber Name _____ Subscriber DOB ____/____/____

Policy ID# _____ Carrier _____

Claims Address _____

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 valid insurance coverage but later determine, for whatever reason, that you were not covered, you acknowledge and agree that you are responsible for the entire fee. In Medicare-assigned cases, the physician/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 agency shown.

_____ _____
Patient, Parent, Guardian or Legal Representative of Patient Date

If signed by party other than patient, indicate relationship below. *Authorized representative must submit copies of legal documents supporting assignment of this authority.*

_____ _____

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Relationship

Witness

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FINANCIAL POLICY

Thank you for choosing Peninsula GI 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 also complete a Patient Information Form before seeing the physician.

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, Checks and all Major Credit Cards. Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered reasonable and necessary under your medical plan. All co-pays are due at the time of treatment.

We <u>DO NOT</u> accept any Blue Cross Covered California, Blue Cross Pathway EPO, or SutterSelect EPO plans. If you have Blue Cross, 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

Please help us serve you better by keeping your scheduled appointments. To cancel or reschedule an office visit, please do so at least 24 hours in advance. Due to the amount of resources allocated for endoscopic procedures, we require at least 3 full business days' notice for cancellation or rescheduling of appointments. For procedures scheduled with MAC anesthesia, we require 5 full business days' notice. ***It is our policy to charge a late schedule adjustment fee of $300 for procedures and $75 for office visits.*** We can waive this fee with a signed doctor's note or if we are able to fill your appointment slot; however, there is no guarantee that we will be able to fill the slot on short notice. The charge for a late cancellation/no-show procedure or appointment will be billed directly to you and not to your insurance.

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 reach out with any questions or concerns.

I have read and understand the Financial Policy in full.

_____
Printed Name of Patient

_____ _____
Signature of Patient, Parent, Guardian or Legal Representative Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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.

Please list below any persons who may be able to access your medical information without first obtaining written consent. Do not list your primary care physician.

Name	Relation
Name	Relation
Name	Relation
Name	Relation

I authorize Peninsula Gastroenterology Medical Group to discuss the details of my medical treatment with the above named parties.

Patient, Parent, Guardian or Legal Representative of Patient _____ Date _____

If signed by party other than patient, indicate relationship below. *Authorized representative must submit copies of legal documents supporting assignment of this authority.*

Relationship _____ Witness _____