Peninsula Gastroenterology Medical Group

Redwood City Office
2900 Whipple Ave, Suite 245
Redwood City, CA 94062
Phone: 650-365-3700
Fax: 650-368-3836

Mountain View Office
2495 Hospital Drive, Suite 600
Mountain View, CA 94040
Phone: 650-964-3636
Fax: 650-368-3836

Gastroenterology Clinic Medical History Check-In Form

Patient Information

- Name: _____ Date of Birth: _____
- Sex: _____ Gender Identity _____ Pronouns: _____
- Address: _____
- Phone Number: _____ Email: _____
- Emergency Contact: _____
- Preferred language: _____

Demographic – Race & Ethnicity

☐ White
☐ Asian
☐ Black/African American
☐ American Indian/Alaskan native
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino
☐ Declined to answer

Social History

Current occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Other _____

Alcohol intake: ☐ No ☐ Yes How many drinks per week_____

Smoking history: ☐ None ☐ Yes How many cigarette per day_____ ☐ Quit, When_____

Recreational drug use: ☐ None ☐ Yes Which drug(s): _____

Medications & Allergies

- List all current medications (including over-the-counter and supplements) ☐ NONE
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- Any medication allergies? ☐ Yes ☐ No
  If yes, list: _____

Immunization:

☐ Hepatitis A, when_____ ☐ Hepatitis B, when_____ ☐ COVID, when_____ ☐ Flu vaccine, when_____

Primary Care Physician: _____

Pharmacy: _____

Past Medical History (check all that apply)

☐ Anemia
☐ Anticoagulation therapy
☐ Anxiety
☐ Arthritis
☐ Arrhythmia
☐ Cancer
☐ Cataracts
☐ Chronic lung disease
☐ Chronic kidney disease
☐ Cirrhosis
☐ Colon polyps
☐ Congestive heart failure
☐ Coronary artery disease
☐ Deep vein thrombosis
☐ Depression
☐ Diabetes mellitus
☐ Fatty liver
☐ Fibromyalgia
☐ GERD (heartburn)
☐ Heart disease or pacemaker
☐ Heart attack
☐ Hepatitis B
☐ Hepatitis C
☐ Hyperlipidemia
☐ Hypertension
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney stone
☐ Osteoporosis
☐ Parkinson Disease
☐ Pancreatitis
☐ Primary biliary cirrhosis
☐ Primary sclerosing cholangitis
☐ Rashes/ skin problem
☐ Sleep apnea
☐ Seizure disorder
☐ Thyroid disease
☐ Other (specify)

Past Surgical History (check all that apply)

☐ Appendectomy
☐ Hysterectomy
☐ Bariatric surgery
☐ C-Section
☐ Bowel resection
☐ Gallbladder removal
☐ Liver transplant
☐ Heart surgery
☐ Pacemaker
☐ Internal defibrillator
☐ Hysterectomy
☐ Breast surgery
☐ Hernia repair
☐ Kidney surgery
☐ Vascular surgery
☐ Orthopedic surgery
☐ Other (specify

Diagnostic tests:

☐ Colonoscopy _____
☐ Upper endoscopy _____
☐ CT/MRI/ultrasound_____
☐ Sigmoidoscopy_____
☐ Capsule endoscopy_____
☐ Others_____

Family History:

	Mother	Father	Paternal grandmother	Paternal grandfather	Maternal grandmother	Maternal grandfather	Sister	Brother
Colon polyps	☐	☐	☐	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐	☐
Crohn Disease	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver cancer	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic cancer	☐	☐	☐	☐	☐	☐	☐	☐
Esophageal cancer	☐	☐	☐	☐	☐	☐	☐	☐
Irritable bowel syndrome	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diverticulitis	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder disease	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

☐ NONE

Review of System *Please check any current problems/symptoms you have experienced in the past 2 weeks*

Constitutional	☐ Chills ☐ Fatigue ☐ Fever ☐ Weight gain ☐ Weight loss ☐ Changes in appetite ☐ Excessive sweating
HEENT	☐ Hearing loss ☐ Sinus pressure ☐ Visual changes ☐ Postnasal drip ☐ Nosebleed ☐ Mouth sores ☐ Trouble swallowing
Respiratory	☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness
Cardiovascular	☐ Chest pain ☐ Pain while walking ☐ Edema ☐ Palpitations ☐ Irregular heart rate ☐ Shortness of breath with exertion ☐ Syncope/passing out
Gastrointestinal	☐ Abdominal pain ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Loss of appetite ☐ Nausea ☐ Vomiting ☐ Indigestion
Genitourinary	☐ Painful urination ☐ Excessive amount of urine ☐ Urinary frequency changes
Endocrine	☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger
Neurological	☐ Dizziness ☐ Extremity numbness ☐ Extremity weakness ☐ Fainting ☐ Headaches ☐ Seizures ☐ Tremors ☐ Speech difficulty ☐ Confusion
Psychiatric	☐ Anxiety ☐ Depression ☐ Mood changes ☐ Agitation ☐ Nervousness
Musculoskeletal	☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Neck pain ☐ Arthritis ☐ Muscle stiffness ☐ Muscle spasm ☐ Joint deformity ☐ Muscle weakness
Hematologic	☐ Easily bleeds ☐ Easily bruises ☐ Lymphedema ☐ Issues with blood clots
Integumentary	☐ Breast discharge ☐ Breast lump ☐ Hives ☐ Itching ☐ Mole change(s) ☐ Rash ☐ Skin lesion ☐ Jaundice
Immunologic	☐ Food allergies ☐ Seasonal allergies

Consent:

I consent to providers obtaining a medication history from pharmacy database ☐ Yes ☐ No

I consent to providers obtaining medical records from external electronic medical system ☐ Yes ☐ No

Signature

_____

Signature (patient) Date (mm/dd/yyyy)

_____

Signature (Legal guardian or representative – if applicable) Date (mm/dd/yyyy)

Peninsula Gastroenterology Medical Group
Gastroenterology & Hepatology

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

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

Peninsula Gastroenterology Medical Group

James D. Torosis, MD, FACP
Vicky W. Yang, MD
Daniel S. Rengstorff, MD
Cynthia W. Leung, MD
Hoan B. Nguyen, PA-C
Gastroenterology & Hepatology

Patient Consent Form for the Use of AI Scribe Software in Medical Practice

Purpose of AI Scribe Software
We are implementing the use of Artificial Intelligence (AI) scribe software in our medical practice to assist with documenting and transcribing your medical information. The AI scribe software will help improve the accuracy and efficiency of your medical records by transcribing discussions during your medical consultation, including symptoms, diagnosis, and treatment plans. The AI tool allows your healthcare provider to focus more on your care during consultations instead of spending time on documentation. There may be occasional inaccuracies in transcription, which will be reviewed and corrected by your healthcare provider. However, the risk of errors in the documentation exists, though safeguards are in place to minimize this. While all reasonable precautions are taken to protect your health information, the use of any electronic system carries an inherent risk of unauthorized access or cyber threats. We use industry-standard encryption and security measures to mitigate these risks.

How the AI Scribe Works

- **Recording and Transcription**: During your appointment, the AI software will listen to the conversation between you and your healthcare provider, and transcribe it in real-time. This allows the healthcare provider to focus on your care and provide accurate, detailed documentation.
- **Data Privacy and Security**: Your personal health information (PHI) is considered confidential and will be handled with the highest security standards. The AI scribe software adheres to all relevant laws, including the Health Insurance Portability and Accountability Act (HIPAA), and your data will not be shared with any third parties without your consent, except as required by law.
- **Role of AI vs. Healthcare Provider**: While AI is used to assist with documentation, it is not intended to replace the clinical judgment or decision-making of your healthcare provider. Your provider will review and finalize the medical record.

Consent to Use AI Scribe Software
By signing this form, you consent to the use of AI-powered scribe software in the documentation of your medical information during your consultations and interactions with your healthcare provider. This consent will apply to all future visits, unless you choose to withdraw your consent. You acknowledge that you have been informed about the use of the AI scribe software, its benefits, and risks, and you have been given the opportunity to ask questions. Your decision to allow or decline the use of this software will not affect the quality of care you receive.

Patient Rights

- You have the right to withdraw your consent at any time, and your healthcare provider will resume traditional methods of documentation without the use of AI scribe software.
- You have the right to request a copy of your medical records as usual.

Consent
By signing below, you confirm that you have read and understand the above information and consent to the use of AI scribe software in your medical care.

_____
Printed Name of Patient

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

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

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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 _____