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DIGESTIVE CARE CONSULTANTS

PATIENT INFORMATION FORM

Patient's Last name:	First:	Middle:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: Single☐ Married☐ Divorced☐ Separated☐ Widowed☐ Partner☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date:	Age:	Social Security Number:	Sex: ☐M ☐F

Birthplace	Maiden Name:	Race:	Ethnicity:
Street address:		Home phone: ( )	Cell Home phone: ( )

City:	State:	Zip Code:	Preferred Language:	Translator Needed
Occupation:	Employer & Employer Address:		Employer phone: ( )	

Email address:

☐ Primary Doctor - Dr's. Name:

How would you like us to contact you for appointment reminder: ☐Home Phone ☐Cell Phone

PHARMACY: Name, address, and phone number or pharmacy you would like medications called in to:

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone: ( )

Is this person a patient here? ☐Yes ☐No | Is this injury: ☐Work Related ☐Auto ☐Personal Injury

Is this patient covered by insurance? ☐Yes ☐No

Please indicate primary insurance: ☐ Blue Cross ☐HMO ☐PPO | ☐ Blue Shield ☐HMO ☐PPO | ☐ Aetna ☐HMO ☐PPO | ☐ Cigna ☐HMO ☐PPO | ☐ Healthnet ☐HMO ☐PPO

☐ ILWU ☐ United Health Care ☐HMO ☐PPO | ☐ Medicare | ☐ Care California ☐HMO ☐PPO | ☐ Secure Horizons/AARP | ☐ Other

Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group Number:	Policy number:	Co-payment: $

Patient relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary Insurance (if applicable:):	Subscribers name:	Group number:	Policy number:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone: ( )	Cell phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Digestive Care Consultants or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Patient's Personal History

DATE:_____

Name_____Date of Birth _____

Home Phone _____Age _____Height _____Weight_____

Occupation _____Referring Physician_____Date of last exam _____

Why are you here today _____

_____

PAST HISTORY

①DIAGNOSIS / ILLNESSES		Circle if you have had:		②SURGERIES	
Type of Illness / Diagnosis	*Year*	*Type of Illness*	*Year*	*Type of Illness*	*Year*
		Stroke			
		Heart Attack			
		Cardiac/Coronary Stent			
		Artificial Heart Valve/Bypass Surgery			
		Sleep Apnea			
		Dialysis/Kidney Failure			

ALLERGIES

Medicine or Food	*Type of Reaction*

CONTINUED ON BACK

PERSONAL HABITS (circle yes or no)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars

How much?_____packs per day How long?_____ Quit Date_____

Yes No Do you drink alcohol? If yes, what kind/how much per day?_____

Yes No Do you or have you used recreational drugs? What type?_____

FAMILY HISTORY:

Yes	No	Liver Disease - Type_____	Yes	No	Colon Cancer
Yes	No	Liver Cancer	Yes	No	Esophagus Cancer
Yes	No	Pancreas Cancer	Yes	No	Stomach Cancer

REVIEW OF SYSTEMS

(Circle "Yes or No" to the following questions)

1. Constitutional

Yes No Fever
Yes No Weight Loss
Yes No Chills
Yes No Night Sweats

2. Ears, Nose, Mouth, Throat

Yes No Ear Pain
Yes No Hoarseness
Yes No Dental Problem
Yes No Difficulty Swallowing
Yes No Snoring
Yes No Painful Swallowing
Yes No Voice Change

3. Cardiovascular

Yes No Chest Pain
Yes No Shortness of Breath with exertion
Yes No Chest Pressure
Yes No Shortness of Breath Lying Down

4. Respiratory

Yes No Cough
Yes No Dry Cough
Yes No Wheezing
Yes No Productive Cough

5. Gastrointestinal

Yes No Anorexia
Yes No Constipation
Yes No Incontinence of Stool
Yes No Diarrhea
Yes No Rectal Bleeding
Yes No Vomiting
Yes No Heartburn
Yes No Nausea
Yes No Abdominal Pain
Yes No Rectal Pain

6. Genitourinary

Yes No Burning or painful urination
Yes No Blood in Urine
Yes No Vaginal Discharge

7. Musculoskeletal

Yes No Muscle Aches/Pain
Yes No Back Pain
Yes No Arthritis
Yes No Joint Swelling
Yes No Joint Pain

8. Psychiatric

Yes No Depression
Yes No Anxiety

9. Endocrine

Yes No Cold Intolerance
Yes No Heat Intolerance
Yes No Increased Thirst
Yes No Frequent Urination

10. Hematologic/Lyphatic

Yes No Easy Bruising
Yes No Easy Bleeding
Yes No Prolonged Bleeding
Yes No Bleeding Gums

11. Skin

Yes No Rash
Yes No Itching
Yes No Pigmentation Change

12. Neurological

Yes No Headache
Yes No Numbness
Yes No Impaired Balance
Yes No Weakness
Yes No Seizure
Yes No Tremor

13. Gynecological

(This section for women only)

Last period_____

If pre-menopausal, are periods normal? ☐ Yes ☐ No

Age at menopause, if applicable _____

Number of: Pregnancies_____
Deliveries_____
Miscarriages_____

Patient's Signature **Date**

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MEDICATION LIST

(Include Vitamins, herbal supplements, over-the-counter meds. etc)

I give permission for Digestive Care Consultants to view/and or download my personal medication history from Surescripts Pharmacy Clearinghouse.

Name _____ DOB _____ _____ *(Initial area)*

Medication	***Dose***	***Frequency***

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Financial Policy

Thank you for choosing us as your healthcare provider. Our goal is to provide quality care in a timely manner. In order to do so, the following policies are to serve as proactive measures to financial obligations.

Proof of Insurance: You are responsible for providing the office with current and accurate insurance information so that we may bill your insurance company within the timely guidelines set forth by your insurance.

Payment of Benefits for Claims: We will bill your insurance company on your behalf. However, you are responsible for all co-pays, deductibles, and any other member liability amounts as determined by your insurance company.

Insurance Coverage: Due to the large amount of insurance plans and policies, it is the responsibility of the patient/responsible party to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of benefits. Furthermore, it is your responsibility to ensure **Digestive Care Consultants** is participating with your insurance plan and/or medical group. Because insurance coverage varies with each plan, it is your responsibility to be familiar with your plan. Because we are a specialty-physician practice, if your insurance is one which requires a medical group assignment, it is your responsibility to ensure we are participating with your medical group. When referred from your primary care provider, it is your responsibility to determine if we are participating

Usual and Customary Rates: We charge what is usual and customary for the Los Angeles metropolitan area. If we are not contracted with your insurance plan, you are responsible for charges regardless of your insurance company's arbitrary determination of usual and customary rates. We will offer negotiated discounts and/or accept your insurance allowable on out-of-network processed claims.

Non-covered Procedures: You are responsible for any non-covered services determined by your insurance company as member liability.

Checks Returned for Non-Sufficient Funds: All checks received for payment of services which are returned by the bank marked "non-sufficient funds" will be charged to you along with a non-sufficient check processing charge of $25.

No Show/Cancellation Policy: In order to provide optimal care, we ask that cancellations, or changes to scheduled appointments, be made at least 24 hours in advance. You may be responsible for a cancellation fee of $50. We understand there are circumstances in which a 24 hour notice is not possible, the fee will be charged at the discretion of management.

Late Policy: Patient care is very important to us. If you arrive more than fifteen (15) minutes late, the next scheduled appointment may be taken in your absence and you may be asked to wait to be seen by the provider. Alternatively, you have the option to reschedule.

I have read, understand, and agree to the financial policy stated above.

Patient Signature _____ Date _____

Patient Name _____

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Date:_____

Print Name_____ DOB _____
(PRINT) First-Middle-Last Name

Patient Telephone number: ( ) _____

I hereby authorize the following medical information to be released, which may include any and all medical information from any medical doctors/hospitals which administered care.

_____

(Please furnish dates of specific records required)

From:

Name: _____

Address: _____

_____

To:

DIGESTIVE CARE CONSULTANTS
23451 MADISON STREET, SUITE 290
TORRANCE, CA 90505

Signature: _____ Date: _____

Authorization Expires One Year after the Signed Date

DIGESTIVE CARE CONSULTANTS

NOTICE OF PRIVACY PRACTICES
CONSENT & ACKNOWLEDGEMENT FORM

The Health Insurance Portability and Accountability Act require that we disclose certain information to our patients regarding the privacy of their medical information and records; as well as our policies regarding the treatment of this information.

Your medical information, records and documents are of a highly confidential nature. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day to day health care operations.

Notice of Privacy Practice This document represents our Notice of Privacy Practices. You have received two copies of this document. Please read it in its entirety, sign and return one copy to our office

Right to Inspect & Obtain Medical Records Our office has established policies and procedures relating to patients obtaining copies of their medical records. Appropriate charges will apply, as well as the patient's signed consent for us to provide such documentation. If parties other than the patient request these records, a signed release/consent is required.

Right to Amend/Append Medical Records State and Federal law provide guidelines in which patients may amend or append their medical records. All documentation in the patient's medical record will be done in accordance with all applicable laws.

Right to Authorize Certain Non-Treatment Disclosures Patients have the right to request that disclosure of their condition and/or treatment is limited as provided by law. Restrictions on disclosures to family members (including parents), employer(s), marketing or advertising affiliates, research organizations, etc. can be made directly with the physician. Verbal/Written approval to disclose protected health information will be obtained prior to disclosure.

Right to Request Restrictions on Use of Medical Records You have the right to request, in writing, specific restrictions on the use of your medical records and protected health information. Upon receipt of such request(s), we will restrict disclosure as provided by applicable law.

Right to Request Alternative Channels of Communication If you wish for us to communicate with you via alternative channels of communication, please make these requests in writing, including the method through which you wish us to contact you. It is our policy to send mail to the address provided on our patient demographics forms, to contact you by telephone at either your home, cellular, or work telephone numbers, and to leave non-descriptive messages via answering machine. If you prefer an alternate channel of communication, again, please put your specific requests in writing. If you prefer to have your results sent

to you via e-mail, please write your e-mail address here:_____

Persons to whom you consent for protected health information to be disclosed to:

Name	Relationship to Patient	Phone Number
_____	_____	_____

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and healthcare operations. I have received a copy of the Notice of Privacy Practices from this office.

Received (Signature of Patient or Patient's Representative): **Date:**

_____ _____