PENINSULA GASTROINTESTINAL SPECIALISTS, INC

COMPLETED BY ☐ PATIENT ☐ STAFF ☐PROVIDER

Name:(Last, First, M.I.) _____,_____ How did you hear about us?: _____

Reason for this visit:_____ Age:_____ Height:_____ Weight:_____

Medical Problems/ Hospitalizations/ Surgeries:

Date

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

Allergies to:

☐ None ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications:_____

Medications: (include BCP, calcium, vitamins, aspirin, herbs)

Dosage

Dosage

Social History:

Occupation:_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other____

Smoker: ☐ No ☐ Yes, I smoke ____Pack(s) a Day for ____Years.
Coffee: ☐ No ☐ Yes, I drink ____cup(s) a Day for ____Years.

Alcohol: ☐ No ☐Yes, I have ____Drink(s) a Day for ____Years.
Interesting Fact About Yourself? _____

Family:

	Age	Medical Problems	Deceased		M	F	Age	Medical Problems	Deceased
Father	____	_____	☐	Children	☐	☐	____	_____	☐
Mother	____	_____	☐	Children	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Children	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Other	☐	☐	____	_____	☐
Brother/Sister	____	_____	☐	Other	☐	☐	____	_____	☐

Review of Systems: (Check all that apply)

Last menses:_____ Birth control method:_____

I have: ☐ Pacemaker ☐ Defibrillator ☐ Valve Replacement ☐ Diabetes ☐ Coumadin/Anticoagulation Use

	Past	Current
Constitutional		
Fatigue	☐	☐
Fevers	☐	☐
Weight Loss/Gain	☐	☐
HEENT/Neurology		
Headaches	☐	☐
Seizures/Strokes	☐	☐
Eye Problems	☐	☐
Hearing/Ear Problems	☐	☐
Respiratory		
Shortness of breath	☐	☐
Asthma/Emphysema	☐	☐
Pneumonia/Bronchitis/TB	☐	☐
Sleep Apnea	☐	☐
Cardiology		
Chest Pains	☐	☐
Heart Attack	☐	☐
Rheumatic Fever/Murmur	☐	☐
Antibiotics before dentist	☐	☐
Leg Swelling/Cramping	☐	☐

	Past	Current
Endocrine		
Thyroid Problems	☐	☐
Hematology/Oncology		
Anemia/Transfusions	☐	☐
Bleeding/Clotting Problem	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Rheum/Derm		
Arthritis/Joint Pains	☐	☐
Immune Disorders	☐	☐
Eczema/Psoriasis	☐	☐
Rashes	☐	☐
Urology		
Prostate Problems	☐	☐
Urinary infections	☐	☐
Kidney Stones	☐	☐
Blood in Urine	☐	☐
Psychology		
Suicide Attempts	☐	☐
Drug/Alcohol Abuse	☐	☐

	Past	Current
Gastroenterology		
Nausea	☐	☐
Vomiting	☐	☐
Heartburn/Regurgitation	☐	☐
Difficulty Swallowing	☐	☐
Ulcers	☐	☐
Hepatitis/Jaundice	☐	☐
Liver Disease	☐	☐
Gallstones	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody/Black Stools	☐	☐
Hemorrhoids	☐	☐
Diverticulosis/Diverticulitis	☐	☐
Abdominal discomfort/pain	☐	☐

Other: _____

(Office use: 10+ complete)

Last colonoscopy (date): _____
Any blood tests recently? ☐ Yes ☐ No
Preferred lab (circle one): Quest or Labcorp or Sutter Mills-Peninsula

Date:_____ Patient Signature:_____

Reviewed & Updated:_____

EYL

2/8/18

PENINSULA
GASTROINTESTINAL
SPECIALISTS, INC

100 S. Ellsworth Ave, Ste. 507
San Mateo, CA 94401
T 650 342-7432
F 650 3423239
www.mygidoctors.com

Acknowledgement of Receipt of Notice of Privacy Practices

To Our Patients:

In accordance with Federal Law on the Patient Privacy, please read the following:

This statement is to advise you that our office has a Privacy Policy (complete policy in waiting room) in place to protect your medical information. In brief, our policy states that our office will keep your medical record information confidential and will use it only for treatment, payment and healthcare operations. The office may release information to other doctors during emergencies, or cases of neglect and abuse. Our policy identifies your rights to access your records, request restrictions on who can see and be informed of your medical information. In short, to keep your communications with this office confidential.

Our Privacy Policy can be reviewed in its entirety, or you may request a copy.

Name: _____ Signature:_____ Date:_____

If not signed by the patient, please indicate relationship: _____

You have my permission to release my medical information to the following: *(please check and list name and phone number)*

☐ Patient Only

☐ Spouse/domestic partner: _____

☐ Others: _____

Would you like information regarding Advanced Directives? ☐ Yes ☐ No

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Date:_____ Primary care physician: _____

Patient's Name:_____ Nickname: _____
(last) (first) (middle)

Address: _____
City State Zip Code

Billing Address *(if different from above)*:_____

Phone #'s
Home: ☐_____Cell: ☐_____email:_____
(check preferred number)

Marital Status: _____ Birthdate: *(MM/DD/YY)*_____ Sex: ☐ M / ☐ F

Ethnicity: ☐ Hispanic or Latino / ☐ Not Hispanic or Latino

Race *(check one box that best describes you)*: ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native American ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Multiracial
☐ Other _____ ☐ Unknown/Not Reported ☐ I prefer not to answer

Preferred Spoken Language *(if other than English)*: _____ ☐ I prefer not to answer

S.S.#: _____ *(optional, unless needed for insurance billing purposes please complete)*

Employer:_____ Work #:_____

Spouse/Domestic Partner: _____ Phone #_____

Emergency Contact *(if different from above)*: _____ Phone #_____

Primary Insurance:_____
(we would like photocopy of all your insurance cards)

Other Insurance: _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED CHARGES. PAYMENT IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT MY CREDIT CARD IS ON FILE AND THAT ANY REMAINING BALANCE I OWE MAY BE CHARGED TO MY CREDIT CARD. I ALSO AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MY INSURANCE CLAIMS. HMO PATIENTS WHO DO NOT HAVE PRIOR AUTHORIZATION TO SEE DR. ONUMA OR DR. LEE WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

Insured's Signature: _____ **Date:** _____

Peninsula Gastrointestinal Specialists, Inc.

Credit Card Billing Authorization Form

Peninsula Gastrointestinal Specialists, Inc. is offering a secure and convenient method of payment for the portion of services that your insurance does not cover.

I authorize the above practice to apply charges to my payment card for all amounts owed to the practice.

I authorize Peninsula Gastrointestinal Specialists, Inc. to charge my credit/debit payment card as payment for any balance put into the "patient responsibility" after my insurance plan has paid its portion.

Multiple attempts will be made to contact you to discuss any remaining balance, and only balances past 90 days will be charged to your card.

Patient Name:_____

Patient Sgnature:_____ Date:_____