# Santa Maria Gastroenterology Medical Group

Today's Date: _____ ☐ New ☐ Update

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Social Security # _____ Date of Birth (mm/dd/yy): _____ Age: _____ ☐Male ☐Female

Primary Care Physician: _____ Physician's Phone Number: _____

Referring Physician: _____ Physician's Phone Number: _____

Employer: _____ Occupation: _____

Employer Address: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Employment Status: ☐ Full ☐ Part ☐ Retired ☐ Self-Employed ☐ Active Military ☐ None ☐ Student

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

In Case of Emergency Contact: _____ Relationship to Patient: _____
Phone Number: _____

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**Primary Insurance:** _____

Insured's Name: _____ ☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Date of Birth: _____

Member ID Number: _____ Group Number: _____

**Secondary Insurance:** _____

Insured's Name: _____ ☐ Male ☐ Female

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Date of Birth: _____

Member ID Number: _____ Group Number: _____

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If there is someone other than you responsible for making healthcare or other legal decisions:

Responsible Party: _____ ☐Self ☐Spouse ☐Guardian ☐Other: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number (optional) _____ Date of Birth: _____

Employer: _____

## Patient's Medicare/Insurance Authorization

Patient's Name _____ Date of Birth _____

I authorize payment of medical benefits to the physician or supplier listed below for services furnished to me or on my behalf. I also authorize the release of any medical or other information necessary to process claims for service rendered to me or on my behalf.

**Santa Maria Gastroenterology Medical Group**

I understand my signature authorizes release of any medical information necessary to process claims related to my healthcare and services provided to me or on my behalf, and authorizes that payment of such services be made to the provider(s) listed above. If "other health insurance" is indicated in Item 9 of the CMS1500 Form, electronically submitted format, or other approved claim form, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned and physician-carrier contracted cases, the physician agrees to accept the charge determination of the Medicare or other carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, copayment and non-covered service amounts. Deductible, coinsurance and copayment amounts are based upon the Medicare / Insurance carrier's determination. I understand copays are due in full at the time services are rendered. I understand it is my responsibility to see that all services are paid in full by my insurance carrier and/or myself in a timely manner. I agree to pay court costs and collection fees and/or reasonable attorney fees if any delinquent account is placed with a collection agency and/or attorney for collection or suit. I acknowledge the information provided on this form is true and correct.

_____ _____
(Patient's Signature) (Date)

_____ _____
(Authorized Representative) (Date)

**Please notify our office if your insurance, address or phone number changes.** If you have any questions regarding our financial policy or insurance billing, please do not hesitate to call our billing office at 805-287-9107
We will be billing your primary and secondary insurance carriers.

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI can be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. I wish to be contacted in the following manner (check all that applies):

- ☐ HOME TELEPHONE_____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ WRITTEN COMMUNICATION
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to fax to this number_____
- ☐ WORK TELEPHONE:_____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Ok to release information to _____

_____
Relationship to Patient: _____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to suing or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. I (patient) have received and acknowledge the Notice of Privacy Practices. A complete copy of Notice of Privacy Practices (NOPP) is posted in our office and is available upon request.

_____ _____ _____
Patient's Signature Print Name Date

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency

TIME: _____

# Santa Maria Gastroenterology Medical Group, Inc.

NEW PRIOR
HMO PPO
MCR CENCAL
WT: _____
HT: _____
BP:_____
PULSE: _____

## Patient Interview Form

**(Please complete this form prior to your Appointment)**

**Today's Date: _____**

**Last Name: _____ First Name: _____ DOB: _____**

**Reason for Visit: _____Primary Care Physician_____**

**Race:**
- ☐White/Caucasian
- ☐Unknown
- ☐Black or African American
- ☐Patient declines to provide
- ☐Asian
- ☐American Indian or Alaska Native
- ☐Native Hawaiian or Other Pacific Islander

**Ethnicity:**
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to Specify

**Gender:**
- ☐Male
- ☐Female
- ☐Other

**Preferred Language:**
- ☐ English
- ☐ Spanish
- ☐ Patient declines

**Contact Preference:**
- ☐ Portal
- ☐ Letter
- ☐ Telephone Call
- ☐ No preference
- ☐ Patient declines to specify

**Past Medical Conditions**

☐None

| | | | | |
|---|---|---|---|---|
| ☐Anemia When:_____ | ☐Arthritis When:_____ | ☐Asthma When:_____ | ☐Breast Cancer When:_____ | ☐Celiac Disease When:_____ |
| ☐Cirrhosis When:_____ | ☐Colitis When:_____ | ☐Colon Cancer When:_____ | ☐Colon Polyps When:_____ | ☐Crohn's Disease When:_____ |
| ☐Diabetes When:_____ | ☐Diverticulitis When:_____ | ☐Gallbladder Disease When:_____ | ☐Gallstones When:_____ | ☐Hepatitis When:_____ |
| ☐High Blood Pressure When:_____ | ☐HIV When:_____ | ☐Irritable Bowel When:_____ | ☐Ischemic Heart Disease When:_____ | ☐Kidney Disease When:_____ |
| ☐Liver Cancer When:_____ | ☐Liver Disease When:_____ | ☐Milk Intolerance When:_____ | ☐Pancreatic Cancer When:_____ | ☐Pancreatitis When:_____ |
| ☐Prostate Cancer When:_____ | ☐Reflux-Heartburn When:_____ | ☐Stomach Ulcer When:_____ | | |

**Previous Procedures**

☐None

| | | | |
|---|---|---|---|
| ☐Appendectomy When:_____ | ☐ Breast Surgery When:_____ | ☐C-Section When:_____ | ☐Gallbladder When:_____ |
| ☐Heart Surgery When:_____ | ☐Hemorrhoidectomy When:_____ | ☐Hernia Repair When:_____ | ☐Hysterectomy When:_____ |
| ☐Liver Biopsy When:_____ | ☐Obesity Surgery When:_____ | ☐Ovary Surgery When:_____ | ☐Thyroid Surgery When:_____ |
| ☐Tubal Ligation When:_____ | ☐Joint Replacement When:_____ | | |

## Diagnostic Studies/Test

☐None

| | | | |
|---|---|---|---|
| ☐Abdominal U/S When:_____ | ☐CT Abdomen/Pelvis When:_____ | ☐HIDA Scan When:_____ | ☐Lower GI x-ray When:_____ |
| ☐UGI x-ray When:_____ | ☐Other:_____ When:_____ | | |

**GI Procedures:**

| | | |
|---|---|---|
| ☐Colonoscopy When:_____ | ☐Endoscopy When:_____ | ☐Sigmoidoscopy When:_____ |

## Social History

Occupation: _____ Number of Children: _____

**Marital Status:**

| | | | |
|---|---|---|---|
| ☐Single | ☐Married | ☐Divorced | ☐Separated |
| ☐Widowed | ☐Civil Union | ☐Unknown | ☐Other |

**Alcohol**

| | | |
|---|---|---|
| ☐None | ☐Daily: How Many? _____ | ☐Less than 2 days a week |
| ☐Rarely | ☐More than 2 days a week | ☐Quit using alcohol |

**Caffeine**

☐None

☐Yes: Type_____ how much/often: _____

**Smoking Status**

| | | | |
|---|---|---|---|
| ☐Current every day smoker | ☐Current some days smoker | ☐Former Smoker: Date Quit_____ | ☐Never Smoker |
| ☐Smoker, current status unknown | ☐Light tobacco smoker | ☐Heavy tobacco smoker | ☐Smokeless |

**Drug Use** **Type:**

☐I have never used recreational drugs

☐I have used recreational drugs in the past _____

☐I am currently using recreational drugs _____

☐I have been treated for substance abuse _____

## Family Medical History

☐ No knowledge of family history

**No family history of** ☐ Colon cancer ☐ Polyps

| **Family Health Status** | **Mother** | **Father** | **Sister** | **Brother** |
|---|---|---|---|---|
| Healthy | ☐ | ☐ | ☐ | ☐ |
| Deceased at Age | ☐_____ | ☐_____ | ☐_____ | ☐_____ |
| Cause of Death | _____ | _____ | _____ | _____ |
| **Diagnoses:** | | | | |
| Alcohol Abuse | ☐ | ☐ | ☐ | ☐ |
| Colitis | ☐ | ☐ | ☐ | ☐ |
| Colon Cancer | ☐ | ☐ | ☐ | ☐ |
| Colon Polyps | ☐ | ☐ | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ |
| MI- Heart Attack | ☐ | ☐ | ☐ | ☐ |
| Stomach Cancer | ☐ | ☐ | ☐ | ☐ |
| Ulcer Disease | ☐ | ☐ | ☐ | ☐ |

**Immunizations**

| | | | |
|---|---|---|---|
| ☐None | ☐Don't Know | ☐Flu Vaccine | ☐Pneumovax |
| ☐Hep A | ☐ Hep B | ☐Usual Military Immunizations | ☐Up to Date |

**Allergies**

☐Patient has no known allergies ☐Patient has no known Drug allergies

☐Aspirin-Like Analgesic, Salicylates ☐ Penicillin ☐Codeine Sulfate ☐Demerol ☐Sulfa (Sulfonamides) ☐Iodine Containing Drugs ☐Valium ☐Morphine and Related ☐Other:_____

**Current Review of Systems Within The Last 30 Days**

**Gastrointestinal**
☐None
☐abdominal pain
☐belching
☐bright red blood per rectum
☐change in bowel habits
☐constipation
☐diarrhea
☐flatulence
☐gas/bloat
☐vomiting blood
☐blood in stool
☐heartburn
☐indigestion
☐black stool
☐nausea
☐stomach cancer
☐vomiting
☐dairy intolerance
☐rectal urgency
☐loss of bowel control

**Cardiovascular**
☐None
☐angina
☐ankle swelling
☐palpitations
☐chest pain
☐heart attack
☐irregular heartbeat

**Respiratory**
☐None
☐asthma
☐chronic cough
☐emphysema
☐hoarseness
☐shortness of breath

**Genitourinary**
☐None
☐difficult urination
☐frequent urine infections
☐blood in urine
☐kidney disease
☐kidney stone

**Musculoskeletal**
☐None
☐arthritis
☐back pain
☐gout
☐joint pain
☐muscle pain
☐stiffness

**Neurological**
☐None
☐stroke
☐migraines
☐seizure disorder
☐TIA
☐falling tendency
☐dizziness
☐frequent headaches
☐numbness in extremities

**Endocrine**
☐None
☐diabetes
☐thyroid disease
☐hair loss
☐cold intolerance
☐heat intolerance
☐excessive thirst

**Hematologic/Lymphatic**
☐None
☐anemia
☐bleeding disorder
☐easy bruising
☐swollen glands

**Eyes**
☐None
☐cataract
☐glaucoma
☐blurred vision
☐double vision
☐pain
☐visual decline

**Ears, Nose, Throat**
☐None
☐difficulty swallowing
☐painful swallowing
☐sore throat
☐hearing loss

**Psychiatric**
☐None
☐alcoholism
☐anxiety
☐depression
☐difficulty sleeping
☐loss of interest in enjoyable activities

**Allergic/Immunologic**
☐None
☐HIV exposure
☐persistent infections
☐allergies (environmental)
☐recurrent hives
☐strong allergic reaction

**Integumentary**
☐None
☐easy bruising
☐rash
☐jaundice

**Constitutional**
☐None
☐loss of appetite
☐weight gain
☐weight loss
☐fevers
☐chills
☐fatigue

# MEDICATION FORM

List *ALL* your current medications including over the counter

Name: _____ Today's Date: _____

Date of Birth: _____

_____I am currently NOT taking any medication

Pharmacy:_____Location:_____

## PLEASE PRINT

| | MEDICATION (DRUG NAME) | DOSAGE MG/MCG | HOW OFTEN TAKEN | DATE STARTED | REASON FOR TAKING |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | | | | | |
| 10 | | | | | |
| 11 | | | | | |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | |
| 15 | | | | | |
| 16 | | | | | |
| 17 | | | | | |
| 18 | | | | | |
| 19 | | | | | |
| 20 | | | | | |

Signature:_____ Date:_____

# Notice of Privacy Practices

Santa Maria Gastroenterology Medical Group Inc.

Effective: October 1, 2010

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have questions about this Notice, please speak to the Office Manager at your physician's office.

Our Medical Group is fully committed to the compliance with HIPAA guidelines:

- Providing appropriate security for our patient records.
- Protecting the privacy of our patient's medical information.
- Providing our patients with proper access to their medical records.
- Maintain our patient information and billing processes in compliance with National HIPAA standards.

**Uses and Disclosure:**
Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need.
Payment: We use and disclose medical information about you to obtain payment for the services we provide.
Health Care Operations: We may use and disclose health information for health care operation purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. We may also call you by name in the waiting room.
Appointment reminders: We may use and disclose health information to contact you to remind you that you have an appointment with our office.
Individuals Involved in your Care, or Payment for Your Care: When appropriate, we may share health information with a person involved in your care or payment for your care, such as a family member.
Notification and Communication with Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your general condition. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are unable or unavailable to agree or object, we will give you every opportunity to object prior to making these disclosures.

**Other Permitted or Required Disclosures:**
As required by law: We must disclose protected health information about you when required to do so by law.
Law Enforcement: We may disclose protected health information under limited circumstances to law enforcement officials in response to a warrant or similar process.
Health Oversight Activities: We may and are sometimes required by law to disclose your health information to healthcare oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by Federal and California law.
Workers' Compensation: We may disclose protected health information to the extent necessary to comply with state law for Workers' Compensation programs.

**When the Office May Not Use or Disclose Your Health Information:**
Except as described in the Notice of Privacy Practices, the office will not use or disclose health information that identifies you without your written authorization. If you do not authorize the Office to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

**Your Rights Regarding Your Protected Health Information:**
The right to review the notice prior to signing this consent. The right to object to the use of health information for directory purposes and the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment or health care operations.
The right to inspect and receive a copy of the health information that may be used to make decisions about your care or payment for your care. This includes medical billing records, other than psychotherapy notes.
To request a copy, you must make your request in writing to the Office. You have a right to receive an accounting of disclosures of your health information made by the office. This office does not have to account or disclose to you, or a family member any specialized government functions or disclosure otherwise permitted or authorized by law, or disclosure to an official that providing this account would be reasonably likely to impede their activities.

You have a right to a paper copy of this notice.

**Changes to this Notice of Privacy Practices:** We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made we are required by law to comply with the contents. We will post a copy of our current notice at each office location. The notice will contain the effective date.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, all complaints must be in writing. You will not be penalized for filing a complaint.