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: _____

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: _____

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 matter. 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

Santa Maria Gastroenterology Medical Group, Inc.

Patient Interview Form

Today's Date: _____

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

Reason for Visit: _____Primary Care Physician_____

Race:

- ☐White/Caucasian
- ☐Black or African American
- ☐Asian
- ☐American Indian or Alaska Native
- ☐Native Hawaiian or Other Pacific Islander
- ☐More than one
- ☐Other
- ☐Hispanic or Latino
- ☐Unknown
- ☐Patient declines to provide

Gender:

☐Male ☐Female ☐Other

Preferred Language: _____

Allergies

☐Patient has no known Drug allergies

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

Immunizations

- ☐None
- ☐Flu Vaccine When: _____
- ☐Pneumovax When: _____
- ☐Hep B When: _____
- ☐Hep A When: _____ ☐ Don't Know
- ☐Usual Military Immunizations

Past Medical Conditions

☐None

- ☐AIDS/HIV infection
- ☐Anemia
- ☐Arthritis
- ☐Asthma/Bronchitis
- ☐Blood Vessel Grafts
- ☐Celiac Disease
- ☐Cirrhosis
- ☐Colitis
- ☐Colon Polyps
- ☐Crohn's Disease
- ☐Diabetes
- ☐Diverticulitis
- ☐Emphysema
- ☐Gallbladder Disease
- ☐Gallstones
- ☐Heart Murmurs
- ☐Hepatitis
- ☐High Blood Pressure
- ☐Irregular Heart Beat
- ☐Irritable Bowel
- ☐Jaundice
- ☐Kidney Disease
- ☐Liver Disease
- ☐Lung Disease
- ☐Pacemaker
- ☐Pancreatitis
- ☐Reflux
- ☐Rheumatic Fever
- ☐Seizures/Epilepsy
- ☐Stomach Ulcer
- ☐Stroke
- ☐Treatment of Cancer_____
- ☐Tuberculosis

☐Pregnant? Weeks of Gestation_____ Date of Last Menstrual Cycle: _____

Diagnostic Studies/Test

☐None

- ☐Abdominal U/S When: _____
- ☐CT Abdomen/ Pelvis When: _____
- ☐HIDA Scan When: _____
- ☐Lower GI X-Ray When: _____
- ☐Upper GI X-Ray When: _____

☐Other: _____

When:_____

Name: _____

Previous Surgeries

☐None

☐Colonoscopy When: _____	☐Endoscopy When: _____	☐Sigmoidoscopy When: _____	☐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: _____			

Social History

Occupation: _____ Number of Children: _____

Alcohol

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

Smoking Status

☐Never smoker	☐Current some days smoker	☐Smokeless Tobacco
☐Current every day smoker	☐Former Smoker: Date Quit_____	

Caffeine

☐None

☐Yes: Type_____ how much/often: _____

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**
Alive	☐	☐	☐	☐
Deceased at Age	☐_____	☐_____	☐_____	☐_____
Cause of Death	_____	_____	_____	_____
Diagnoses:				
Alcoholism	☐	☐	☐	☐
Colitis	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐
Other	_____	_____	_____	_____

Name: _____

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: _____