Patient Personal Information

Patient Name: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth date: _____ Sex: ☐ **M** ☐ **F** Marital Status: _____ Fax#: _____

Email: _____ Soc.Sec. #: _____ Driver Lic #: _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Hispanic ☐Black/African American
☐White ☐Other ☐Other Pacific Islander

Language: ☐English ☐Indian ☐Russian ☐Spanish ☐Other

Pharmacy/Name/City: _____ Pharmacy Phone: _____

Pharmacy Fax: _____ Height: _____ Weight: _____

Employment: ☐ Retired ☐ Full Time ☐ Part-time ☐ Self Employed

Company Name: _____Position:_____

Address: _____City/State: _____ Zip: _____

Work Phone: _____ Ext:____/ Other: _____ Fax# _____

Best Phone# to contact you directly: _____
(To confirm your appointments)

Spouse/Guardian Information

Name: _____ SS#_____

Birth date: _____ Employer Name: _____

Work Phone_____ Ext: _____ Cell# _____Other:_____

Payment Information: ☐ Insurance #1 ☐ Insurance#2 ☐Cash

Primary Ins: _____ **Secondary Ins** _____

Policy Holder: _____ Policy Holder: _____

Referred By: _____

Emergency Contact

Name of Contact: _____Relationship:_____

Street/City/State/Zip: _____ Phone: _____

I hereby give authorization that payment of insurance benefits be made directly to **Newport Coast Gastroenterology** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all the cost of collection and reasonable attorney fees. I hearby authorize for the release of all information necessary to secure the payment of benefits.
I hereby give authorization for the practice to access my Rx external history.

Signature: _____ **Date:** _____

Name:_____ **Age:** _____ **Date:** _____

Please List All Medications You Are Taking	**Please List All <u>Drug</u> Allergies**

HEALTH QUESTIONAIRE

Patient Name: _____ Age: _____ Date: _____

HISTORY OF PAST ILLNESS

	DATE	TYPE	HOSPITAL
Serious Illnesses	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Operations	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Injuries	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE (at death)	CAUSE
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____ B / S	_____	_____ B / S	_____
Brother (B)	_____ B / S	_____	_____ B / S	_____
Sister (S)	_____ B / S	_____	_____ B / S	_____
	_____ B / S	_____	_____ B / S	_____
Husband/Wife	_____	_____	_____	_____
Children	_____ S / D	_____	_____ S / D	_____
Son (S)	_____ S / D	_____	_____ S / D	_____
Daughter (D)	_____ S / D	_____	_____ S / D	_____

SOCIAL HISTORY

Birthplace _____

Circle one: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Do you have dependents at home? ☐Yes ☐No If yes, how many? _____

Alcoholic beverages: ☐Never ☐Yes ☐ If yes, please note **number of drinks per week: _____**

Tobacco: ☐Never smoked ☐Quit – when? _____ ☐Packs/Day _____

Drugs (illicit): ☐None ☐In Past ☐Rarely ☐Frequently

Exercise: Type _____ Frequency _____

Are you currently dieting? ☐Yes ☐No If so, what type of diet? _____

Occupation: _____

Any known allergies? _____

Patient Name: _____ Age: _____ Date: _____

REVIEW OF SYSTEMS

GENERAL:
- Have been in good health most of your life?..... **YES** **NO**
- Any recent weight change?..... **YES** **NO**

SKIN:
- Skin disease..... **YES** **NO**
- Jaundice..... **YES** **NO**
- Hive, edema, rash, or itching..... **YES** **NO**
- Frequent skin infection or boils..... **YES** **NO**
- Abnormal pigmentation or color..... **YES** **NO**

HEAD-EYE-EARS-NOSE-THROAT:
- Headaches or migraines..... **YES** **NO**
- Eye disease or injury..... **YES** **NO**
- Do you wear eye glasses or contacts..... **YES** **NO**
- Double vision or vision loss..... **YES** **NO**
- Glaucoma..... **YES** **NO**
- Cataracts..... **YES** **NO**
- Itchy, sneezy, or runny nose..... **YES** **NO**
- Nosebleeds..... **YES** **NO**
- Chronic sinus trouble..... **YES** **NO**
- Trouble with smell or taste..... **YES** **NO**
- Ear disease..... **YES** **NO**
- Trouble hearing..... **YES** **NO**
- Dentures/Partials..... **YES** **NO**
- Sore mouth or tongue..... **YES** **NO**
- Sore throat or recent tonsillitis..... **YES** **NO**

NECK:
- Stiffness..... **YES** **NO**
- Enlarged glands..... **YES** **NO**

BREAST (FEMALES)**:**
- Lumps..... **YES** **NO**
- Pain or discharge..... **YES** **NO**
- Mammogram..... **YES** **NO**
- Date of last mammogram..... _____

RESPIRATORY:
- Cold symptoms now..... **YES** **NO**
- Coughing up blood..... **YES** **NO**
- Asthma or wheezing..... **YES** **NO**
- Difficulty breathing..... **YES** **NO**
- Pleurisy or pneumonia..... **YES** **NO**
- Tuberculosis..... **YES** **NO**
- Any trouble with lungs..... **YES** **NO**

CARDIOVASCULAR:
- Chest pain or angina..... **YES** **NO**
- Shortness of breath at night..... **YES** **NO**
- Heart attacks or heart trouble..... **YES** **NO**
- Heart murmur..... **YES** **NO**
- Palpitations..... **YES** **NO**
- Swelling of the feet or ankles..... **YES** **NO**
- Rhumatic fever..... **YES** **NO**
- Pain in legs or buttocks when walking..... **YES** **NO**

Do you have any of the following?

GASTROINTESTINAL:
- Does food stick in throat?..... **YES** **NO**
- Peptic ulcer (stomach or duodenal)..... **YES** **NO**
- Vomiting blood or food..... **YES** **NO**
- Gallbladder problems..... **YES** **NO**
- Liver disease or hepatitis..... **YES** **NO**
- Cramping or pain in the abdomen..... **YES** **NO**
- Bleeding or pain with bowel movements..... **YES** **NO**
- Black stool..... **YES** **NO**
- Hemorrhoids..... **YES** **NO**
- Recent change in bowel habits..... **YES** **NO**
- Frequent diarrhea..... **YES** **NO**
- Constipation..... **YES** **NO**
- Hernia or hernia surgery..... **YES** **NO**

GENITOURINARY:
- Kidney disease or failure..... **YES** **NO**
- Kidney stones..... **YES** **NO**
- Burning or painful urination..... **YES** **NO**
- Blood in urine..... **YES** **NO**
- Protein in the urine..... **YES** **NO**
- Bladder kidney infections..... **YES** **NO**
- Frequent urination..... **YES** **NO**
- Recent change in night time urination..... **YES** **NO**
- Venereal disease..... **YES** **NO**
- Prostate problems (males)..... **YES** **NO**

GYNECOLOGICAL (FEMALES)**:**
- Number of pregnancies..... _____
- Number of miscarriages..... _____
- Last menstrual period..... _____
- Date of last pap smear..... _____
- Vaginal discharge..... **YES** **NO**

MUSKULOSKELETAL:
- Arthritis..... **YES** **NO**
- Gout..... **YES** **NO**
- Varicose veins..... **YES** **NO**
- Chronic back pain..... **YES** **NO**

HEMATOLOGIC:
- Blood disease..... **YES** **NO**
- Phlebitis..... **YES** **NO**
- Abnormal bruising or bleeding..... **YES** **NO**
- Anemia..... **YES** **NO**

ENDOCRINE:
- Diabetes..... **YES** **NO**
- Thyroid disease..... **YES** **NO**
- Abnormal hair growth or loss..... **YES** **NO**
- Hormone therapy..... **YES** **NO**

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NEWPORT COAST GASTROENTEROLOGY, INC

In order to better serve your medical care, this office will now implement the following policies:

APPOINTMENTS

- Failure to keep or cancel your scheduled appointment within 24 hours time will necessitate a cancellation fee of $25.00.
- A return visit following any procedures, radiology testing, or laboratory analysis are usually needed. If a doctor requests that you schedule a follow-up, please make a follow-up appointment. Telephone consultations cannot be made in lieu of a follow-up appointment.

CO-PAYMENTS/DEDUCTIBLES

- Co-payments are due at the time services are rendered. Payment of cash or check only; no credit cards. A $10.00 billing fee will be charged every time a statement is sent to collect a co-payment.
- If you present for your appointment without your co-pay, your appointment will be rescheduled.
- Unmet deductibles will be collected at the time of an office visit and prior to any tests, procedures.

PAYMENTS

- There will be a $25.00 fee charged for all returned checks.
- If delinquent payments have not been made within 3 months, a 100% billing fee will be added to your account before it is sent to the collection agency.

PRESCRIPTIONS

- Written prescriptions will be given at the time of an office visit. Please be aware of your medication needs at every office visit. Your physician will give you enough refills of all your routine medications to last until they want to see you again. If you need a refill prior to an office visit, please contact your pharmacy and have them fax a request to our office. This office cannot guarantee that your request for a refill can be completed the same day as the request (please be aware of your medication needs before you completely run out of those medications).

I UNDERSTAND AND ACKNOWLEDGE THE ABOVE OFFICE POLICIES.

_____

Patient/Responsible Party Signature Date

_____

Print Name Date of Birth

Acknowledgement of Receipt of Notice of Privacy Practices

NEWPORT COAST GASTROENTEROLOGY, INC

ABHAY S. PARIKH, M.D.

TEL: (949) 548-6652 FAX: (949) 548-1435

I hereby acknowledge that I received a copy of Newport Coast Gastroenterology's Notice of Privacy Practices. This notice describes how Newport Coast Gastroenterology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to other through he HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at: One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

Print Patient Name: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian ☐ Other: _____

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 be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

NEWPORT COAST GASTROENTEROLOGY, INC

Abhay S. Parikh, M.D.

Patient Financial Agreement

Dear Patient or Guardian:

Our goal is to provide you with the best medical care available. A clear understanding of our financial arrangement is essential for a successful doctor/patient relationship.

Our office will call your insurance company to verify eligibility and benefits. We cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. It is **your responsibility** to be aware of any limitations such as pre-existing clauses, second opinion requirements, etc written in your policy. It is recommended that you also contact your insurance company regarding your benefits and coverage. For those patients using the **POS** option of your plan; you must contact your insurance carrier prior to performing any procedures to alert them that you are going out of your plan to use the PPO option.

Charges for your treatment will be billed to your insurance company. However, if your insurance company has not paid their portion of the charges within 60 days, the account will revert to **your responsibility**. Regarding insurance payments, the phrases "more than the allowable charge" or "exceeds usual and customary amount" may be used by your insurance company to states that fees may exceed their allowance. If there is a major discrepancy between our fees and your insurance carrier's allowance, our office will assist you in providing your insurance company with additional information as needed for your claim.

My signature below indicates that I have read and understand the above statements. I have received a copy of this agreement for my records.

Signed: _____ Date: _____

Witness: _____ Date: _____