

REGISTRATION FORM

Name: _____
Last First Middle

Home Address: _____
Street Apt # City/State Zip

Gender: F M **Birth Date:** ____/____/____ **Last 4-digits of SSN** _____

E-mail Address: _____

Contact: _____
(Home Number) (Work Number) (Cell Number)

Employed By: _____ **Occupation:** _____

Emergency Contact: _____
Name Relationship Phone Number

Pharmacy: _____
Name Address Phone Number

Primary Care Physician's Name: _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone Number: _____ **Fax Number:** _____

Please list any additional physicians who you would like copies of your procedure/medical reports mailed to: _____

Who referred you to our office? _____

Requested GI Physician: Dr. Frank Farrell Dr. Cathleen Cabansag No Preference

X _____
(Signature of Patient OR Guardian)

Date: ____/____/____

PATIENT QUESTIONNAIRE

Date: _____ **Name:** _____ **DOB:** _____

Reason for Visit: Colonoscopy Upper Endoscopy Office Visit for: _____

Height _____ Weight _____

Do any of the following apply to you? None

- Pacemaker Defibrillator **Home Oxygen**
- Kidney Dialysis Blood Thinners (Such as Coumadin, Plavix, Aggrenox) If Yes, Cardiologist Name _____

SYSTEM REVIEW: Do you experience any of the following: _____ None

- | | | | | | |
|--|---|--|--|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Rash | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Lumps | <input type="checkbox"/> Cough | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sores | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> <u>Fainting</u> | <input type="checkbox"/> Hives | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> <u>Nail Changes</u> | <input type="checkbox"/> <u>Wheezing</u> | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> <u>+ TB Test</u> | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> <u>Fatigue</u> | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Excess Thirst | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> <u>Swollen Glands</u> | <input type="checkbox"/> Nausea | <input type="checkbox"/> Painful Bowels |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Bloody Nose | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Yellow eye/skin |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> <u>Heat Intolerance</u> | <input type="checkbox"/> Burning w/ Urination | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> <u>Joint Swelling</u> | <input type="checkbox"/> <u>Bleeding Gums</u> | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> <u>UTI's</u> | <input type="checkbox"/> Constipation | |

Provide details/list other symptoms: _____

PAST MEDICAL HISTORY: Have you had any of the following diseases: None

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Hepatitis A, B, or C | | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Atrial Fibrillation | | <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Cancer (specify : _____) | | | | |

PAST SURGICAL HISTORY: If you have had any of the follow surgeries, list date and type if any. None

- | | | | |
|--------------------------------------|-------------|---|-------------|
| <input type="checkbox"/> Gallbladder | Date: _____ | <input type="checkbox"/> Appendix | Date: _____ |
| <input type="checkbox"/> Stomach | Date: _____ | <input type="checkbox"/> Hysterectomy | Date: _____ |
| <input type="checkbox"/> Appendix | Date: _____ | <input type="checkbox"/> Heart Bypass | Date: _____ |
| <input type="checkbox"/> Hernia | Date: _____ | <input type="checkbox"/> Transplantation | Date: _____ |
| <input type="checkbox"/> Colon | Date: _____ | <input type="checkbox"/> Heart/Artery/Stent | Date: _____ |
| <input type="checkbox"/> Other: | Date: _____ | | |

PAST ENDOSCOPIC HISTORY: What prior endoscopies have you had? None

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> Upper Endoscopy | Date: _____ | Results: _____ |
| <input type="checkbox"/> Colonoscopy | Date: _____ | Results: _____ |

I am a returning patient; please see my chart for previous procedures

Authorization for Use or Disclosure of Protected Health Information

The information may be used/disclosed for each of the following purposes:

- At my request For employment purposes
 For payment/insurance
 Other: _____

I understand that after the custodian of records discloses my protected health information, it may no longer be protected by federal privacy laws.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization is fully understood and is made voluntarily on my part. I release San Francisco Gastroenterology from any legal liability that may arise from the release of information requested.

Signature of patient (or patient's
personal representative)

Date

Printed name of patient OR representative

Representative's authority to sign for
patient (*i.e parent, guardian, power of
attorney for healthcare, executor*)

Notice to Our Patients regarding Office Policies

Thank you for your confidence in our practice and we appreciate your continued support. We have implemented an office policy to aid us in your visit to our office and our procedure centers.

INSURANCE: While our office can offer some guidance regarding insurance coverage, it is **ultimately your responsibility** to ensure that any tests, procedures, medication and professional referrals are covered by your insurance plan.

APPOINTMENTS/PROCEDURES: To allow our office to provide quality care and efficient service, we request that you cancel any appointments that you cannot keep at least 24 hours prior to your scheduled visit. This allows patients who require immediate care to have that appointment time. Failure to notify our office within that time frame will result in a \$25.00 missed appointment fee. **Failure to cancel your procedure within 5 business days prior to your procedure date will result in a \$250.00 fee.** Please call (415) 749-6900 to cancel appointments or procedures. We understand that situations such as emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis. If you reach us after normal business hours, please leave a message with our answering service.

LATE POLICY: We make every effort to be on time for all our appointments. **Patients arriving more than 10 minutes after their appointment time will be asked to either be seen in a later available timeslot or reschedule their appointment.** We apologize for any inconvenience this might cause.

PRESCRIPTIONS: There is a 48 hour (2 business days) turnaround time for all prescription refill requests. If you are traveling or need to refill a prescription prior to the weekend, please call our office ahead of time to allow us to process your request accordingly.

By signing below I agree that I have read and understand the items listed above and agree to all terms and conditions listed in the San Francisco Gastroenterology Office Policy.

Patient Name: _____ Date: _____

Patient Signature: _____

Dear Patient,

In our effort to best serve you, we ask that you please **read carefully** the billing and financial information outlined below.

You **may** be advised to undergo certain endoscopic procedures and investigations for diagnosis, management and the possible treatment of your symptoms or conditions. Most procedures can be safely and effectively performed in our affiliated Endoscopy Centers.

When choosing to schedule your procedure, our staff will assist in obtaining the necessary authorizations and can offer you general guidance regarding insurance coverage; it is **your responsibility** to ensure that any tests, procedures, medication and professional referrals are covered by your insurance plan. As a rule, most large commercial plans cover both upper (EGD) and lower (Colonoscopy) endoscopy. We make every attempt to bill for the services rendered; however, the findings of your procedure may result in up to **four (4) separate bills**. They are:

1. Gastroenterologist Fee (Physician charge for the procedure).
2. Pathology fee and/or lab fee (including all lab/facility and pathology charges).
3. Facility fee (Including use of the endoscopy suite, recovery, medications, supplies and nursing care).
4. Anesthesiologist fee.

Depending on your coverage, you may also be responsible for co-insurance or co-pay. All co-pays, co-insurance, and deductible payments are due at the time of your visit for procedure. If special arrangements are necessary, please call our office for further assistance.

With the implementation of The Affordable Care Act, some insurance coverage has changed or been discontinued, **we strongly advise that you check with your insurance carrier to avoid any unforeseen financial obligations.**

Should you have additional questions, please contact our office at (415) 749-6900.

Thank you. We are pleased to assist you.

The SFGI Team

I have read the above. _____
Signature