Riverside Digestive and Liver Health Clinic

6927 Brockton AVE STE 2A Riverside, CA 92506-3807

Patient Registration

Date: ____________ **Primary Phone #**______________________________

Secondary phone#______________________________

Social Security #____________________________

Email: ______________________________

If you wish to opt out of electronic Health Information Exchange (HIE) please check this box ☐

Name____
Last Name First Middle Initial

MailingAddress____
Street Number Street Name Apt#

City______________________________ **State** _______________ **Zip**______________________

Birthdate _______________ **Sex (circle One) Male / Female** **Marital Status** S M W D
Month/ Day/ Year

Race_____________________ **Ethnicity**________________ **Preferred Language**________________

Referring Doctor__________________________ **Primary Care Physician**__________________________

Referring Doctors Telephone # ____________________________ **Fax #** __________________________

In case of emergency who should be notified. _________________________ **Phone** _________________

Power of Attorney (if applicable) ______________________________________ **Phone**_________________

***Supporting documentation required and should be submitted at time of appointment. ***

EMPLOYER

Patient Employer_______________________________________ **Occupation**_____________________

Employer Address__________________________________ **Business Phone**_____________________

PRIMARY INSURANCE

Insurance Company Name ______________________________ **Medical Group**____________________

Insurance Address ____

Insurance Telephone # _________________ **Policy ID#** _____________________ **Group#**__________

Name of Insured _______________________ **Insured Birthdate**__________ **Soc. Sec#**______________
Month/Day/Yr

Relation to Patient________________________________

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www.riversidedigestiveclinic.com

SECONDARY INSURANCE (if no secondary insurance please move on to the signature portion***)***

Insurance Company Name ____________________________________ **Medical Group**_________________

Insurance Address ____

Insurance Telephone # _____________________ **Policy ID#** _____________________ **Group#** __________

Name of Insured ____ **Insured Birthdate**____________

Soc. Sec#_______________________________ **Relationship to Patient** ______________________________

Assignment of Benefits and Release of Information

I, the undersigned, certify that I (or my dependent) have insurance and assign directly to Riverside Digestive and Liver Health Clinic., all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_________________________________ _________________ __________

Signature of Patient or Responsible Party **Relationship to patient** **Date**

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PATIENT MEDICAL HISTORY
PLEASE COMPLETE USING BLACK INK

1) Patient Name ____________________________ Date ______________ Med. Rec.# ________________
2) Date of Birth _______________ Age ___________ Height ______ Weight _______ ☐ Male ☐ Female
3) Primary Care Physician: ________________________ Referred By: ________________________________
4) What gastrointestinal problem (chief complaint) led you to see us __________________________________

____

5) When did the problem begin? ____

6) Have you had any of the following diagnostic tests related to your gastrointestinal problem?

☐ Colonoscopy ☐ EGD ☐ Barium Enema ☐ Barium Swallow ☐ CT scan ☐ Upper GI X-Rays

☐ Ultrasound Other: ____

7) List all of your medical diagnoses such as hypertension, diabetes, thyroid disorder, arthritis, or other conditions.

MEDICAL DIAGNOSIS	YEAR

8) List all of your operations (surgeries).

YEAR	OPERATION	FACILITY	PHYSICIAN

PATIENT MEDICAL HISTORY (cont.)

PLEASE COMPLETE USING BLACK INK

9) Are you allergic to any medications? ☐ Yes ☐ No If YES, what reaction did you experience?

MEDICATION ALLERGIES	REACTION

10) Please list all of the medications you are CURRENTLY TAKING, including over-the-counter medications such as aspirin or ibuprofen, as well as any birth control pills, vitamins, and herbal remedies. Attach an extra sheet if necessary.

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBING PHYSICIAN

11) Please provide the following Pharmacy Information:

Pharmacy Name ______________________________ Address ____

City _____________________________ Phone ________________________ Fax ________________________

If you wish to opt out of medication sharing please check this box ☐

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor)	☐ Yes	☐ No	Weekly Consumption ___________
Tobacco (cigarettes,cigar,chewing tobacco)	☐ Yes	☐ No	Usage/Frequency ___________
IV or Recreation Drugs	☐ Yes	☐ No	Usage/Frequency ___________
Recent colonoscopy/EGD?	☐ Yes	☐ No	Where? ___________
Recent Imaging? (CT, XRAY, U/S)	Yes	No	Where? ___________
Recent labs?	Yes	No	Where? ___________

FAMILY HISTORY

	Mother	Father	Siblings	Son	Daughter	Grandmother	Grandfather
Barrett's Esophagus	☐	☐	☐	☐	☐	☐	☐
Cancer							
Breast	☐	☐	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐	☐	☐
Esophagus	☐	☐	☐	☐	☐	☐	☐
Lung	☐	☐	☐	☐	☐	☐	☐
Pancreas	☐	☐	☐	☐	☐	☐	☐
Stomach	☐	☐	☐	☐	☐	☐	☐
Other___________	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease/Colitis	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Wheat Allergy (Celiac)	☐	☐	☐	☐	☐	☐	☐
Other?___________	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING

GASTROINTESTINAL

	YES	NO
Difficulty swallowing		
Heartburn		
Nausea		
Vomiting		
Abdominal Pain		
Rectal Bleeding		
Constipation		
Diarrhea		
History of Liver problems		
History of Pancreas problems		
Weight Loss		
Weight Gain		
Chronic cough		
Back pain		
Anemia		
Hepatitis A Vaccination		
Hepatitis B Vaccination		

CARDIOVASCULAR/NEUROLOGIC

	YES	NO
Chest pain		
Trouble breathing		
Edema (swelling of legs/feet)		
Palpitations		
Headaches		
Seizures		
General Weakness		
Numbness		

CONSTITUTIONAL SYMPTOMS

	YES	NO
Sleep Apnea		
Latex Allergy		
Reaction to anesthesia		

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SUMMARY OF PRIVACY PATIENTS

________ **PATIENT CONSENT**

Initials

You, the patient, are granting consent to Riverside Digestive and Liver Health Clinic (including all affiliated providers), to treat and render medical services related to your visit, present and future.

USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Initials

You the patient authorize the use and disclosure of your protected health information for the purposes of treatment, payment, and health care operations. This includes but is not limited to: lab tests, medical records obtained from outside sources, radiology, and information obtained during visits with staff of Riverside Digestive and Liver Health Clinic. You authorize the following persons (or class of persons) to use/disclose your protected health information via verbal, written, fax or electronic transmission for purposes of treatment, payment, and health care operations: physicians, nurse practitioners, nurses, medical assistants, front office, back office, and billing staff. Our full Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request, however, if we decide to grant your request, we are bound by our agreement.

INSURANCE COVERAGE WAVIER

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Initials

If your insurance policy requires a primary care physician referral, prior approval, or other pre-authorization for you to receive services, it is **your responsibility** to see that the necessary referral is current and has been presented to Riverside Digestive and Liver Health Clinic. **prior** to receiving services. If no required prior approval or pre-authorization is present in advance, or is not required, you will be personally responsible for paying for any services rendered to you by Riverside Digestive and Liver Health Clinic. (Including all affiliated providers). At time of service, you, the insured, must pay all deductibles and/or copays. You may be responsible for payment of any claim that is: (1) denied; (2) unpaid due to deductible; (3) partially paid; (4) partially paid due to your insurance carriers' arbitrary determination of "usual or customary" rates; and/or (5) coinsurance. If your claim is involved in litigation and/or is being disputed among insures, you are still financially responsible. You must pay any balance that your insurance carrier designates as your responsibility. **It is also your responsibility to notify the office of any changes in coverage or insurance plans as soon as those changes have been made to avoid delays of care, or services rendered.**

________**48 HOUR CANCELLATION NOTICE**

Initials

Please note that it is the policy of this office to charge a $35.00 cancellation fee for **BOTH OFFICE AND PROCEDURE APPOINTMENTS** not cancelled 48 hours prior to the scheduled appointment, and for patients that **do not show up (NO SHOW)** for the procedure and/or scheduled appointment. Notification to the facility **is not proper notification.**

________________________ ________________________ __________

Patient Name Patient Signature Date