David T. Wong, M.D.

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PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY & COMPLETE ALL BOXES

LAST NAME	FIRST NAME	MIDDLE NAME	SEX ☐ MALE ☐ FEMALE
SOCIAL SECURITY #	DRIVER'S LICENSE #	DATE OF BIRTH	AGE	HOME PHONE

SOCIAL SECURITY #	DRIVER'S LICENSE #	DATE OF BIRTH	AGE	HOME PHONE
ADDRESS		CITY/STATE/ZIP		CELL PHONE
OCCUPATION	EMPLOYED BY	EMPLOYER ADDRESS		BUSINESS PHONE
NAME OF SPOUSE		EMPLOYED BY		BUSINESS PHONE
IN CASE OF EMERGENCY: Notify		RELATIONSHIP TO PATIENT		PHONE

PRIMARY PHYSICIAN *(REQUIRED)*	**REFERRING PHYSICIAN** *(REQUIRED)*

PRIMARY INSURANCE	**SECONDARY INSURANCE**
NAME OF INSURANCE___________________	NAME OF INSURANCE___________________
STREET ADDRESS ___________________	STREET ADDRESS ___________________
CITY, STATE, ZIP ___________________	CITY, STATE, ZIP ___________________
PHONE ___________________	PHONE ___________________
SUBSCRIBER ___________________	**SUBSCRIBER** ___________________
RELATION TO PATIENT ___________________	RELATION TO PATIENT ___________________
SOCIAL SECURITY# ______________ DOB ________	SOCIAL SECURITY# ______________ DOB ________
POLICY # ___________________	POLICY # ___________________
GROUP # ___________________	GROUP # ___________________
EFFECTIVE DATE ___________________	EFFECTIVE DATE ___________________

CONSENT FOR TREATMENT / INSURANCE AUTHORIZATION

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physician listed above. Transmittal by Fax is authorized. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any other balance not paid by my insurance (excluding contractual allowances). If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/we agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is placed with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account I/we agree to pay the attorney's fees and court fees incurred for collection.

PATIENT'S SIGNATURE ____ DATE ________________________

Tri Valley Gastroenterology

Please fill out completely and bring to your first visit.

Name: ______________________ Who may we thank for referring you? ______________

Reason for this Visit: ______________________ Age: ________ Height: ________ Weight: ________

Medical Problems-Hospitalizations-Surgeries: **Date** **Date**

1) ______________________ 5) ______________________
2) ______________________ 6) ______________________
3) ______________________ 7) ______________________
4) ______________________ 8) ______________________

Allergies: ☐ None, Allergies to: ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications: ______________________

Medications: (include BCP, calcium, vitamins, aspirin, herbs) **Dosage** **Dosage**

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Social History: Occupation: ______________________ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other________

Smoker: ☐ NO ☐ YES, I smoke approximately_______Pack(s) a Day for _____Years. Alcohol: I have approximately ______Drink(s) a Day.

Family:	**Age**	**Medical Problems**	**Deceased**		**M**	**F**	**Age**	**Medical Problems**	**Deceased**
Father	___	______________	☐	Children	☐	☐	___	______________	☐
Mother	___	______________	☐	Children	☐	☐	___	______________	☐
Brothers/Sisters	___	______________	☐	Children	☐	☐	___	______________	☐
Brothers/Sisters	___	______________	☐	Children	☐	☐	___	______________	☐
Brothers/Sisters	___	______________	☐	Children	☐	☐	___	______________	☐

Review of Systems: (Please check all that apply) Last Menses:__________Birth Control Method:____________________

I have: ☐ Pacemaker ☐ Mastectomy ☐ Dentures ☐ Eyeglasses ☐ Hearing Aid ☐ ______________

☐ Diabetes ☐ High blood pressure ☐ Heart Failure ☐ Organ Transplant ☐ Valve Replacement ☐ Coumadin/Warfarin use

I have:

	Past	*Current*
Constitutional		
Fevers	☐	☐
Weight Changes	☐	☐
Fatigue/Weakness	☐	☐
HEENT/Neurology		
Headaches	☐	☐
Seizure/Strokes	☐	☐
Eye Problems	☐	☐
Hearing/Ear Problems	☐	☐
Respiratory		
Shortness of breath	☐	☐
Asthma/Emphysema	☐	☐
Pneumonia/Bronchitis/TB	☐	☐
Sleep Apnea	☐	☐
Cardiology		
Chest Pains	☐	☐
Heart Attack	☐	☐
Rheumatic Fever/Murmur	☐	☐
Antibiotics before dentist	☐	☐
Leg Swelling or Cramps	☐	☐

	Past	*Current*
Endocrine		
Thyroid Problems	☐	☐
Hematology/Oncology		
Anemia/Transfusions	☐	☐
Bleeding/Clotting Disorders	☐	☐
Immune Deficiency	☐	☐
Cancer	☐	☐
Rheumatology		
Arthritis/Joint Pains	☐	☐
Immune Disorders	☐	☐
Eczema/Psoriasis	☐	☐
Rashes	☐	☐
Urology		
Prostate Problems	☐	☐
Urinary Infections	☐	☐
Kidney Stones	☐	☐
Blood in Urine	☐	☐
Psychology		
Suicide Attempts	☐	☐
Drug/Alcohol Abuse	☐	☐

	Past	*Current*
Gastroenterology		
Nausea	☐	☐
Vomiting	☐	☐
Heartburn/Regurgitation	☐	☐
Difficulty Swallowing	☐	☐
Ulcers	☐	☐
Hepatitis/Jaundice/Liver Dis.	☐	☐
Gallstones	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody/Black Stools	☐	☐
Diverticulosis or Diverticulitis	☐	☐
Abdominal discomfort/pain	☐	☐

DATE: __________________ PATIENT SIGNATURE: ______________________________

DO NOT WRITE BELOW THIS LINE

HEALTH QUESTIONNAIRE

Consent to the Use and Disclosure of Health Information

Name_______________________________________ DOB________________ SS#____________________

I understand that as part of my healthcare, Tri Valley Gastroenterology originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

☐ I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with:

☐ Patient Only
☐ Family member or friend____________________________
☐ Physician
☐ Other____

Detailed messages regarding test results can be left on my answering machine/voicemail:

☐ Yes ☐ No ☐ Phone #________________

☐ Other Restrictions____

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for Tri Valley Gastroenterology.

____ ________________

Signature of Patient or Legal Representative Date

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

** Conditions and limitations may apply; obtain additional information from front desk.*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.