PENINSULA GASTROINTESTINAL SPECIALISTS, INC

**COMPLETED BY ☐ PATIENT ☐ STAFF ☐PROVIDER**

Name:(Last, First, M.I.) _____,_____ How did you hear about us?: _____

Reason for this visit:_____ Age:_____ Height:_____ Weight:_____

## Medical Problems/ Hospitalizations/ Surgeries:

Date

1)_____ 6)_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

## Allergies to:

☐ None ☐ Latex ☐ Iodine/Shellfish ☐ Anesthetic ☐ Medications:_____

## Medications: (include BCP, calcium, vitamins, aspirin, herbs)

Dosage

Dosage

## Social History:

Occupation:_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other____

Smoker: ☐ No ☐ Yes, I smoke ____Pack(s) a Day for ____Years.
Coffee: ☐ No ☐ Yes, I drink ____cup(s) a Day for ____Years.

Alcohol: ☐ No ☐Yes, I have ____Drink(s) a Day for ____Years.
Interesting Fact About Yourself? _____

## Family:

| | Age | Medical Problems | Deceased | | M | F | Age | Medical Problems | Deceased |
|---|---|---|---|---|---|---|---|---|---|
| Father | ____ | _____ | ☐ | Children | ☐ | ☐ | ____ | _____ | ☐ |
| Mother | ____ | _____ | ☐ | Children | ☐ | ☐ | ____ | _____ | ☐ |
| Brother/Sister | ____ | _____ | ☐ | Children | ☐ | ☐ | ____ | _____ | ☐ |
| Brother/Sister | ____ | _____ | ☐ | Other | ☐ | ☐ | ____ | _____ | ☐ |
| Brother/Sister | ____ | _____ | ☐ | Other | ☐ | ☐ | ____ | _____ | ☐ |

## Review of Systems: (Check all that apply)

Last menses:_____ Birth control method:_____

***I have:*** ☐ Pacemaker ☐ Defibrillator ☐ Valve Replacement ☐ Diabetes ☐ Coumadin/Anticoagulation Use

| | Past | Current |
|---|---|---|
| Constitutional | | |
| Fatigue | ☐ | ☐ |
| Fevers | ☐ | ☐ |
| Weight Loss/Gain | ☐ | ☐ |
| HEENT/Neurology | | |
| Headaches | ☐ | ☐ |
| Seizures/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/Cramping | ☐ | ☐ |

| | Past | Current |
|---|---|---|
| Endocrine | | |
| Thyroid Problems | ☐ | ☐ |
| Hematology/Oncology | | |
| Anemia/Transfusions | ☐ | ☐ |
| Bleeding/Clotting Problem | ☐ | ☐ |
| Immune Deficiency | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Rheum/Derm | | |
| 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 Disease | ☐ | ☐ |
| Gallstones | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Bloody/Black Stools | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ |
| Diverticulosis/Diverticulitis | ☐ | ☐ |
| Abdominal discomfort/pain | ☐ | ☐ |

Other: _____

*(Office use: 10+ complete)*

Last colonoscopy (date): _____
Any blood tests recently? ☐ Yes ☐ No
Preferred lab (circle one): Quest or Labcorp or Sutter Mills-Peninsula

Date:_____ Patient Signature:_____

Reviewed & Updated:_____

EYL

2/8/18

PENINSULA
GASTROINTESTINAL
SPECIALISTS, INC

100 S. Ellsworth Ave, Ste. 507
San Mateo, CA 94401
T 650 342-7432
F 650 3423239
www.mygidoctors.com

## Acknowledgement of Receipt of Notice of Privacy Practices

To Our Patients:

In accordance with Federal Law on the Patient Privacy, please read the following:

This statement is to advise you that our office has a Privacy Policy (complete policy in waiting room) in place to protect your medical information. In brief, our policy states that our office will keep your medical record information confidential and will use it only for treatment, payment and healthcare operations. The office may release information to other doctors during emergencies, or cases of neglect and abuse. Our policy identifies your rights to access your records, request restrictions on who can see and be informed of your medical information. In short, to keep your communications with this office confidential.

Our Privacy Policy can be reviewed in its entirety, or you may request a copy.

Name: _____ Signature:_____ Date:_____

If not signed by the patient, please indicate relationship: _____

You have my permission to release my medical information to the following: *(please check and list name and phone number)*

☐ Patient Only

☐ Spouse/domestic partner: _____

☐ Others: _____

Would you like information regarding Advanced Directives? ☐ Yes ☐ No

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Date:_____ Primary care physician: _____

Patient's Name:_____ Nickname: _____
*(last) (first) (middle)*

Address: _____
*City State Zip Code*

Billing Address *(if different from above)*:_____

Phone #'s
Home: ☐_____Cell: ☐_____email:_____
*(check preferred number)*

Marital Status: _____ Birthdate: *(MM/DD/YY)*_____ Sex: ☐ M / ☐ F

Ethnicity: ☐ Hispanic or Latino / ☐ Not Hispanic or Latino

Race *(check one box that best describes you)*: ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native American ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Multiracial
☐ Other _____ ☐ Unknown/Not Reported ☐ I prefer not to answer

Preferred Spoken Language *(if other than English)*: _____ ☐ I prefer not to answer

S.S.#: _____ *(optional, unless needed for insurance billing purposes please complete)*

Employer:_____ Work #:_____

Spouse/Domestic Partner: _____ Phone #_____

Emergency Contact *(if different from above)*: _____ Phone #_____

Primary Insurance:_____
*(we would like photocopy of all your insurance cards)*

Other Insurance: _____

**I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED CHARGES. PAYMENT IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT MY CREDIT CARD IS ON FILE AND THAT ANY REMAINING BALANCE I OWE MAY BE CHARGED TO MY CREDIT CARD. I ALSO AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MY INSURANCE CLAIMS. HMO PATIENTS WHO DO NOT HAVE PRIOR AUTHORIZATION TO SEE DR. ONUMA OR DR. LEE WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.**

**Insured's Signature:** _____ **Date:** _____

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EDWARD K. ONUMA, M.D., Ph.D.
EUGENE Y. LEE, M.D.

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## Appointment Cancellation Policy:

We appreciate your understanding and cooperation in ensuring we can provide timely and highest quality care to our patients. We kindly ask that you provide us with at least 48 hours notice if you need to cancel or reschedule your appointment. This allows us to offer the appointment slot to another patient who may need medical care.

**Cancellation Fees:** If you cancel your appointment with less than 48 hours notice, or if you fail to show up for your appointment without notifying us, a fee of $50 for office visit, and $100 for scheduled procedures will be applied.

**How to Cancel or Reschedule:** To cancel or reschedule your appointment, please call our office during business hours at 650-342-7432 (M-F, 9:00am-5:00pm). You may also leave a voicemail if you are calling after hours. Please do not cancel appointments via email, as we may not receive the notice in time.

**Exceptions:** We understand that emergencies and unforeseen circumstances arise. If you have a genuine emergency or illness that prevents you from attending your scheduled appointment, please contact us as soon as possible so that we can waive any applicable cancellation fees. Please note, we consider exceptions on a case-by-case basis.

**Late Arrivals**: If you arrive late for your appointment, we will do our best to accommodate you, but please be aware that your appointment may need to be rescheduled to the end of the day in order to ensure that our other patients are not inconvenienced. We appreciate your cooperation with our cancellation policy. By adhering to these guidelines, you help us provide better service to you and all our patients.

## Artificial intelligence (AI) Technology Consent:

AI technology, such as ambient listening transcription, is increasingly being utilized in the healthcare field for patient communications, telehealth visits, transcription, and more. To ensure the confidentiality and security of your protected health information, these third party applications are required to adhere to all applicable regulations including HIPAA. AI and similar technologies are integral to enhance and assist with your healthcare.

### Patient Acknowledgement

By signing below, you acknowledge and consent to the appointment cancellation policy and use of AI technologies. Any applicable fees are not billable to insurance and are the sole responsibility of the patient.

Patient Name: _____ Date: _____

Patient Signature: _____