Gastroenterology Consultant
Medical Group Inc.
8120 Timberlake Way #101
Sacramento, CA 95823
916-423-2124 916-423-2127 fax
gastroconsultantsmedgrp.com

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Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement on the bottom of this form.

Last Name_____ First Name _____ M.I. _____

Home Address _____

Home Phone_____ Work Phone _____

Employer Name and Address _____

Social Security Number _____ Date of Birth _____

Name and Phone Number of person to
contact in the case of an emergency _____

Primary Insurance
Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number _____

Secondary Insurance
Company Name and Phone Number _____

Billing Address _____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number _____

I hereby authorize payment of medical benefits billed to my insurance to Gastroenterology Consultants Medical Group Inc. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. I also agree to inform the office of any changes in insurance coverage prior to my visit.

_____ _____
signature of patient or guardian *date*

POS® Reorder # 1119639

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Gastroenterology Consultants Medical Group Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Gastroenterology Consultants Medical Group Inc. can refuse to treat me.

I have been informed that Gastroenterology Consultants has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing the consent.

I understand that I may revoke this consent at any time by notifying GCMG, Inc., in writing, but if I revoke my consent, such revocation will not affect any actions that GCMG, Inc. took before receiving my revocation.

I understand that GCMG, Inc. has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that GCMG, Inc. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that GCMG, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, GCMG, Inc. must adhere to such restrictions.

Do we have permission to:	Yes	No
Leave a message on your answering machine at home	☐	☐
Leave a message at your place of employment	☐	☐
Discuss your medical condition with any member of your household?	☐	☐

If yes whom:_____ Relationship_____

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____
Printed name of patient or patient's representative

_____
Relationship to the patient

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History

(PATIENTS : PLEASE COMPLETE FORMS)

Name_____ **Referring Physician** _____

Date of Birth _____ **Age** _____ **Date of Visit** _____

Chief Complaint (Main Reason for Visit)

Abdominal pain
Abnormal X-Ray or Imaging exam
Abnormal liver enzymes
Anemia
Blood in stool
Colon screening
Constipation
Diarrhea
Change in Bowel Habits
Heartburn/Indigestion
Hepatitis C _ Hepatitis B
Nausea or vomiting
Swallowing difficulty
Weight loss/poor appetite
Other not listed _____
_____
_____

History of Present Illness

Patient Notes (Please describe the nature of your problem in the space below. Include things like how long you've noticed the problem, is it steady or does it come and go, does it occur day or night, or before or after meals. Where is the symptom located, where does it go and what does it feel like? Is it sharp, burning, cramping, dull, full etc? What makes it better and what makes it worse? Rate severity (1 mildest - 10 most severe) and whether it is improving or worsening over time. What other symptoms do you associate with your main problem?) _____

_____

_____

_____

_____

_____

_____

_____

_____

Previous testing or treatments for this problem _____

_____

_____

_____

_____

Personal Medical History

Surgery:	Details	Date / Hospital
Appendectomy		
Breast		
Gallbladder		
Hernia repair		
Hysterectomy / ovaries		
Other intestinal/abdominal		
Tonsillectomy		
Stomach/duodenal ulcer		
Surgery not listed above		

Hospitalizations other than Surgery	Date / Hospital

Current Medical Problems

Arthritis _____
Asthma _____
Atrial fibrillation/ other rhythm disturbance _____
Anxiety/Depression _____
Chronic bronchitis/emphysema _____
Congestive Heart Failure _____
Coronary artery disease/angina _____
Diabetes mellitus _____
High blood pressure _____
High cholesterol/triglycerides _____
Kidney failure _____
Osteoporosis/osteopenia _____
Sleep apnea _____
Thyroid problems _____
Other _____
_____

Medications: (Include over the counter and herbal products)

Name	Dose / Frequency	Condition Being Treated / Duration

Allergies to Medications: (Include latex/tape, iodine and serious adverse reactions other than allergy)

Medication	Reaction

POS® Reorder # 1119643

Social History

Tobacco No Yes Quit / when_____ Packs per day_____ # Years _____
Alcohol No Yes Quit / when_____ Drinks per wk _____ # Years _____
Recreational Drug Use No Yes Quit / when_____ Used needles Drugs used _____
Diet vegetarian lactose-free caffeine-free diabetic regular other _____

Marital Status Married Single Divorced Widow/Widower Occupation_____

Family History: (include **age** of diagnosis in affected family member)

	Father	Mother	Brother/Sister	Other/ Other Generations
Colon cancer	_____	_____	_____	_____
Colon polyp	_____	_____	_____	_____
Uterine/ovarian cancer	_____	_____	_____	_____
Stomach/small bowel cancer	_____	_____	_____	_____
Renal/ urethral cancer	_____	_____	_____	_____
Breast cancer	_____	_____	_____	_____
Liver disease/ Hemochromatosis	_____	_____	_____	_____
Gallbladder disease	_____	_____	_____	_____
Colitis/Crohn's disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

Review of Systems **(check if you have any of the following and describe further in space below)**

Gastrointestinal
- Y N Heartburn/regurgitation
- Y N Difficulty swallowing
- Y N Painful swallowing
- Y N Filling up quickly at meals
- Y N Nausea or vomiting
- Y N Abdominal pain
- Y N Irregular bowel habits
- Y N Bloating/gas
- Y N Incomplete evacuation of bowels
- Y N Symptoms improve with evacuation
- Y N Blood in stool or on toilet paper
- Y N Mucous in stool
- Y N Loss of control of bowels
- Y N Intolerance to milk
- Y N Intolerance to other foods
- Y N Jaundice
- Y N Gallstones
- Y N Hepatitis A, B, C, other
- Y N Cirrhosis
- Y N Fluid in abdomen (ascites)
- Y N Pancreatitis

Skin
- Y N Rash
- Y N Itching
- Y N Unusual hair loss

General
- Y N Decreased appetite
- Y N Unexpected weight loss
- Y N Unexpected weight gain
- Y N Fatigue
- Y N Fever or Chills

Eyes
- Y N Blind field of vision
- Y N Cataracts

ENT
- Y N Hearing loss/ ringing
- Y N Sore throat/hoarseness
- Y N Sinusitis/Sinus drainage

Respiratory/Lung
- Y N Sleep apnea / CPAP mask
- Y N Respiratory complications with sedation
- Y N Chronic bronchitis/emphysema
- Y N Difficulty breathing
- Y N Persistent cough
- Y N Asthma

Cardiovascular
- Y N Chest pain, pressure, angina
- Y N Coronary artery disease
- Y N High blood pressure
- Y N Swelling in feet or legs
- Y N Abnormal heart rhythm
- Y N Prostate cancer/enlarged

Renal/Urinary/Kidney
- Y N Renal failure/insufficiency
- Y N Electrolyte disturbances
- Y N Kidney stones
- Y N Difficulty with urination
- Y N Urinary tract infections

Endocrine
- Y N Diabetes
- Y N Thyroid disease
- Y N Osteoporosis/osteopenia

Gynecology
- Y N Pregnant now?
- Y N Endometriosis
- Y N Heavy periods

Musculoskeletal
- Y N Joint pain/arthritis
- Y N Back / neck pain
- Y N Muscle aching/weakness

Neurologic
- Y N Headaches
- Y N Strokes/ CVA
- Y N Seizures

Psychiatric
- Y N Depression
- Y N Anxiety
- Y N Suicide attempt
- Y N Swollen/tender lymph node

Blood / Lymph
- Y N Anemia
- Y N Bruise easily
- Y N Past blood transfusion

Comments _____