

**PEDIATRIC GASTROENTEROLOGY ASSOCIATES**

2577 Samaritan Dr, Suite 815  
San Jose, CA 95124  
(408) 358-3573  
(408) 356-2888

**PATIENT REGISTRATION INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_ SS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ ALTERNATIVE/MESSAGE PHONE: (\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ ID# \_\_\_\_\_

MEMBER'S NAME: \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

CO-PAYMENT (circle one): YES NO AMOUNT: \$ \_\_\_\_\_

Is PreAuthorization or a Referral required for specialists? YES NO AUTH/REFERRAL# \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ ID# \_\_\_\_\_

MEMBER NAME: \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

CO-PAYMENT (circle one): YES NO AMOUNT: \$ \_\_\_\_\_

Is PreAuthorization or a Referral required for specialists? YES NO AUTH/REFERRAL# \_\_\_\_\_

I assign all Benefits for Medical Services rendered to Pediatric Gastroenterology Associates. I authorize Pediatric Gastroenterology Associates to Release all necessary private health information for the purpose of securing the payment of benefits.

TODAY'S DATE: \_\_\_\_\_

**SIGNATURE OF MEMBER OR INSURED**

**PEDIATRIC GASTROENTEROLOGY ASSOCIATES**

***PARENT INFORMATION***

PATIENT NAME: \_\_\_\_\_

MOTHER'S Name \_\_\_\_\_ SS# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ CELL # ( ) \_\_\_\_\_

ADDRESS (if different): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK # ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

FATHER'S Name \_\_\_\_\_ SS# \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ CELL # ( ) \_\_\_\_\_

ADDRESS (if different): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK # ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that I am financially responsible for all charges incurred, whether or not covered by insurance. I agree to make all co-payments and /or deductible payments at the time of service.

I understand that it is my responsibility to supply complete insurance information or pay in full at the time of service.

I understand that Pediatric Gastroenterology Associates will assess a fee for any appointments not cancelled one business day in advance (\$100 for Consultation Appointments and \$50 for Follow-Up Appointments).

The above registration and insurance information is current and factual.

XX \_\_\_\_\_ Date: \_\_\_\_\_  
**SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY**

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At this office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment for example, a review of your file by a specialist doctor whom we may involve in your care.

- We may use or disclose your health information for payment of your services. For example we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.
- We may use your information to contact you either by phone or with a reminder card in the mail to remind you of an upcoming appointment. If you are not home, we may leave a message on an answering machine or with a person who may answer the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some of all of your health care information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as describe above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we will not use or disclose your health information as described above. W will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or phone number you prefer.
- You have the right to transfer copies of your health insurance to another practice. We will mail your files for you. We may charge you a reasonable fee for this service.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but we will add new information.
- You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of this change in writing.  
You may file a complaint to the Department of Health and Human Service, Independence Ave, S.W., Room 509f, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information, please contact our Privacy Officer, Viki Escobar, at (408) 358-3573.

This notice goes into effect as of April 14, 2003.

-----  
**ACKNOWLEDGEMENT**

I have received a copy of Pediatric Gastroenterology Associates' Notice of Privacy Practices.

DATE: \_\_\_\_\_

**Signed: XX** \_\_\_\_\_ Print Name: \_\_\_\_\_

If signing as a parent or guardian, please note the name of the patient \_\_\_\_\_

**PEDIATRIC GASTROENTEROLOGY ASSOCIATES**  
**2577 Samaritan Dr., Suite 815**  
**San Jose, CA 95124**  
**(408)-358-3573**

*AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I AUTHORIZE: \_\_\_\_\_

(child's primary care physician and/or referring physician)

\_\_\_\_\_  
(physician's address)

to release to Pediatric Gastroenterology Associates medical records pertaining to my child's gastroenterology complaints including (but not limited to) growth charts, progress notes, laboratory results (including blood and stool testing), and x-ray results.

This authorization will remain in effect while my child is under the care of Pediatric Gastroenterology Associates.

I have the right to revoke or limit this authorization at any time.

*I hereby authorize you to release* \_\_\_\_\_ *All Records or*

\_\_\_\_\_ *Partial Records as specified below:*

\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(parent or guardian)

**Medical Information Regarding Your Child (Page 1/2)**

Last Name:	First Name:	Date of Birth:
Who does the patient live with?	How many brothers and sisters?	
Pediatrician:	Other doctors involved in the care:	

**State briefly the purpose of your visit to our office:**

.....

.....

**REVIEW OF SYSTEM**

Has the patient ever been diagnosed with any of the following?

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
<b>Gastrointestinal</b>			<b>Genitourina</b>			<b>Muscular</b>			<b>Respiratory</b>		
Diarrhea			Kidney disease			Muscle pain			Asthma		
Constipation			Urine infection			Arthritis			Pneumonia		
Abdominal pain			Urine accidents			Back pain			Chronic Cough		
Nausea			<b>Neurology</b>			Neck pain			Hoarseness		
Vomiting			Seizures			<b>Psychosocial</b>			<b>Skin</b>		
Rectal bleeding			Migraines			Depression			Rash		
Trouble Swallowing			Cerebral Palsy			Anxiety disorder			Bruises		
Heartburn			Weakness			Alcoholism			Eczema		
Soiling			Headache			Substance Abuse			Hives		
Jaundice			<b>Ear, Nose &amp; Throat</b>			<b>General</b>			<b>Endocrine</b>		
<b>Eye</b>			Nosebleeds			Fever			Diabetes		
Blindness			Deafness			Fatigue			Thyroid disorders		
Cataracts			Canker sores			Dizziness			<b>Blood</b>		
Glaucoma			<b>Cardiac</b>			Weight loss			Bleeding disorder		
<b>Birth History</b>			Chest pain			Loss Appetite			Anemia		
Normal			Murmur								
Premature			Blood Pressure								

**LABORATORY TESTS**

Please indicate if your child had any of the following medical tests done:

TEST	NO	YES	Test	NO	YES		NO	YES
Blood			MRI			Liver Biopsy		
Stools			X Ray			Skin tests		
Urine			Procedure			Breath tests		
Ultrasound			Endoscopy					
CT scan			Colonoscopy					

**Medical Information Regarding Your Child (Page2/2)**

**PAST HISTORY**

Please explain YES answers in details description in the box provided

Any Allergy? (Including medications, food, environmental)	<b>NO</b>	<b>YES</b>	Names:	
Any surgeries?			Surgery	Date
Any hospitalization?			Reason	Date
Currently on any medications?			Names	Dosage
Any milk daily?			Amount per day	

**FAMILY HISTORY**

Please indicate if parents/siblings/grandparents have any of the following:

<b>DISEASE</b>	<b>NO</b>	<b>YES</b>	<b>DISEASE</b>	<b>NO</b>	<b>YES</b>	<b>DISEASE</b>	<b>NO</b>	<b>YES</b>
Ulcerative Colitis			Stomach ulcer			Cystic Fibrosis (CF)		
Crohn's disease			Helicobacter pylori infection			Thyroid disease		
Polyps			Intestinal/Stomach Cancer			Diabetes type 1		
Hepatitis			Intestinal Lymphoma			Blood disorder		
Liver disease			Liver cancer			Bleeding disorder		
Jaundice			HIV / AIDS			Autoimmune disease		
Gallbladder disease			Tuberculosis			Arthritis		
Celiac disease			Food Allergy			Psychiatric disease		
GERD (Reflux)			Asthma			Behavioral disease		
Irritable Bowel Syndrome (IBS)			Eczema					
Constipation			Skin Diseases					

**Person completing this form: .....**

**Provider Signature. ....**

**Date:.....**