

PEDIATRIC GASTROENTEROLOGY ASSOCIATES

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

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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: | Age: |
| Who does the patient live with? | How many brothers and sisters? | |
| Pediatrician: | Other doctors involved in the care: | |

Why does your child need to be evaluated by the GI specialist? _____

REVIEW OF SYSTEM

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

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

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

| | NO | YES | | |
|--|----|-----|-----------------------|---------|
| Any Allergy? (Including medications, food, environmental) | | | Names of medications: | |
| 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 and indicate relationship to patient:

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

Person completing this form: _____

For office only:

Physician Signature. **Date:**.....