INLAND EMPIRE GASTROENTEROLOGY MEDICAL GROUP

PATIENT INFORMATION SHEET

IN ORDER TO BETTER SERVE YOU PLEASE COMPLETE THE INFORMATION TO THE BEST OF YOUR ABILITY. WE ARE REQUESTING EMERGENCY CONTACT INFORMATION IN THE EVENT OF ANY UNFORSEEN SCHEDULE CHANGES OR IN THE EVENT OF AN EMERGENCY DURING YOUR VISIT TO OUR FACILITY.

LAST NAME	FIRST NAME MIDDLE INIT.	Social Security #

DATE OF BIRTH	AGE	M/F	HOME PHONE CELL PHONE

ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION	PHONE

SPOUSE or PARENT **(If patient is a minor)**	RELATIONSHIP	PHONE	ALTERNATE PHONE

EMERGENCY CONTACT (Need alternate Phone #)	RELATIONSHIP	PHONE	ALTERNATE PHONE

EMAIL ADDRESS **<u>For Patient Portal Access</u>	REFERRING DOCTOR, **PHONE / FAX (IF OUT OF AREA)**

INSURANCE CARRIER	ID#	PHONE

SUBSCRIBERS NAME (primary insured)	Subscribers Date of Birth	Subscribers Social Security #

INSURANCE INFORMATION

In the event your insurance information, including secondary insurance has changed please inform us immediately in order to verify eligibility, co-payments and/or deductibles. Failure to inform us of any changes can result in a delay of service and/or cancellation of appointments or scheduled procedures. We make every attempt to communicate up to date information regarding services provided and insurance requirements based on the information provided by you. **Your insurance may pay all, some or none of your bill. Any remaining balance, deductible and co-payments are the patient's responsibility.**

CONSENT FOR MEDICAL TREATMENT AND FINANCIAL ARRANGEMENTS

I hereby authorize Inland Empire Gastroenterology Medical Group, Inc. (IEGMG) to examine and provide medical treatment/tests as needed. I authorize my insurance company to pay by check made out directly to Inland Empire Gastroenterology Medical Group. I assume full responsibility for any balance due. I authorize Inland Empire Medical Group, Inc to release any medical or personal information necessary for either medical care or in processing insurance claims. <u>I understand it is my responsibility to know which hospital, emergency room, laboratory, radiology facilities, specialists and providers are covered under my insurance plan/s</u>. It is Inland Empire Gastroenterology Medical Group's procedure to share Protected Health Information with labs, radiology, consulting physicians, hospitals and pharmacies as needed. We will only exchange the necessary Protected Health Information required in effort to better serve you.

I authorize IEGMG to share my health information with the following person/s, unless otherwise instructed:

I have read, understand and authorize the above information.

Signature of Patient or Legal Representative (relationship) Date

HIPPA Privacy Rule of Patient Authorization Agreement

Inland Empire Gastroenterology Medical Group

Authorization for the Disclosure of Protected Health Information for treatment, payment, or healthcare operations (164.508 (a))

I, _____ understand that as part of my health care, Inland Empire Gastroenterology Medical Group, originates, and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communications among the health professionals who may contribute to my health care;
- A source of information or 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 health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to view ***Inland Empire Gastroenterology Medical Group*** notice prior to signing this authorization. I authorize the disclosure of my ***Protected Health Information*** as specified below for the purposes and the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I understand that:

- I have the right to review Inland Empire Gastroenterology Medical Group Notice of information practices prior to signing this consent;
- That Inland Empire Gastroenterology Medical Group, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notices to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purpose;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry put treatment, treatment, payment, or healthcare operations and that Inland Empire Gastroenterology Medical Group is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Inland Empire Gastroenterology Medical Group has already taken actions in reliance thereon.

Signature of Patient or Legal Representative: _____

Printed Name of Patient or Legal Representative: _____

Date: _____

Medication Sheet

Name of medication	Dosage	How medication is taken	Reason for medication

No Medications check here _____

Patients Name: _____ **DOB:** _____

Patient Name: _____ DOB: _____

Review of Systems

PLEASE ONLY CHECK THE SYMPTOMS THAT APPLY

Constitutional

- ☐ None
- Chills O
- Depression O
- Dizziness O
- Fainting O
- Fever O
- Headache O
- Loss of sleep O
- Loss of weight O
- Sweats O

Gastrointestinal

- ☐ None
- Abdominal Pain O
- Poor appetite O
- Bloating O
- Bowel changes O
- Change in bowel habits O
- Constipation O
- Diarrhea O
- Excessive hunger O
- Excessive thirst O
- Gas O
- Hemorrhoids O
- Indigestion O
- Heartburn O
- Nausea O
- Rectal bleeding O
- Vomiting O
- Vomiting blood O

ENMT

- ☐ None
- Bleeding gums O
- Difficulty swallowing O
- Earache O
- Hay fever O
- Hoarseness O
- Nosebleeds O
- Persistent cough O
- Sinus problems O

Genitourinary

- ☐ None
- Blood in urine O
- Frequent urination O
- Lack of bladder control O
- Painful urination O

Cardiovascular

- ☐ None
- Chest pain O
- High blood pressure O
- Low blood pressure O
- Poor circulation O
- Rapid heartbeat O
- Swelling in ankles O
- Varicose veins O

Integumentary

- ☐ None
- Bruise easily O
- Rash O
- Sore that won't heal O

Allergic/Immunologic

- ☐ None
- HIV exposure O
- Persistent infections O
- Strong allergic reaction or urticaria O

Hematologic/Lymphatic

- ☐ None
- Bleeding gums O
- or palpable lymph nodes O
- Easy bruising O
- Prolonged bleeding O

Neurological

- ☐ None
- Dizziness O
- Fainting O
- Frequent headaches O
- Migraine O
- Numbness/tingling O
- Seizures O
- Tremors O
- Vertigo O

Psychiatric

- ☐ None
- Anxiety O
- Depression O
- Difficulty sleeping O
- Panic attacks O

Respiratory

- ☐ None
- Asthma O
- Cough O
- Dyspnea O
- Excessive sputum O
- Hemoptysis O
- Shortness of breath with exercise O
- Wheezing O