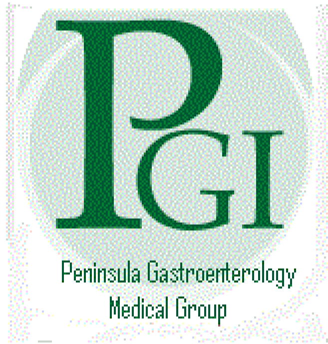

2900 Whipple Avenue, Ste. 245
Redwood City, CA 94062
(650) 365-3700
Fax: (650) 368-3836

James Torosis, MD
Vicky Yang, MD
Daniel Rengstorff, MD
Cynthia Leung, MD
Carmen Lim, MD
Lauren Faidley, MHS, PA-C

Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________

Date Of Birth:______________________ Age:______________________

Notes:______________________

Email

Please check one as your preferred email for communications

- ◯ Personal:______________________
- ◯ Work:______________________

Race

Select one or more

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ Chinese
- ◯ English
- ◯ French
- ◯ Spanish; Castilian
- ◯ Tagalog
- ◯ Patient declines to specify

Contact Preference

- ◯ Home #
- ◯ Cell #
- ◯ Work #
- ◯ Patient declines to specify
- Other:______________

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Latex
- ◯ Penicillins
- Other:______________
- Other:______________
- Other:______________

Current Medications

- [ ] None

Name	Dose	How taken?

Immunizations

- [ ] None

- [ ] Hep A, adult When:______________
- [ ] Hep B, adult When:______________

Diagnostic Studies/Tests

- [ ] None

- [ ] Colonoscopy When:______________
- [ ] Endoscopy When:______________
- [ ] Sigmoidoscopy When:______________
- [ ] Abdominal Ultrasound When:______________
- [ ] CT Abdomen When:______________
- [ ] MRI When:______________

Other:______________

Past or Present Medical Conditions

- [ ] None

GASTROINTESTINAL: Acid Reflux; Crohn's Disease; Ulcerative Colitis; Colon cancer; Colon polyps; Diverticulitis/Diverticulosis; Gastric Ulcer; Gastritis; Hepatitis B; IBS; Cirrhosis; Hepatitis C

CARDIOVASCULAR: Arrhythmia; Congestive Heart Failure; High blood pressure; Heart Attack; Hyperlipidemia

PULMONARY: Asthma; C.O.P.D.; Sleep Apnea w/CPAP

MUSCULOSKELETAL: Rheumatoid arthritis; Osteoarthritis; Spine Disease

ENDOCRINE: Diabetes Mellitus; Thyroid Disorder

HEMATOLOGICAL: Anemia; Bleeding Problems

NEUROPSYCHIATRIC: Depression; Anxiety; Bipolar Disorder; Parkinson's; Seizures; Stroke or Paralysis

OTHER: Other:______________ Other:______________ Other:______________

Previous Procedures

- None

Appendectomy When:______	Joint Replacement When:______	Colon Resection When:______	Gastric By-Pass When:______	Mastectomy When:______
Open Heart Surgery- When:______	Pace Maker placement When:______	Coronary stent placed When:______	AICD or internal defibrillator When:______	Gallbladder removed When:______
Hysterectomy When:______	Other:______	Other:______	Other:______	Other:______
Other:______	Other:______	Other:______	Other:______	Other:______

Social History

Occupation:______ Number of Children:______

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Other

Alcohol

- None

Type	Number	Frequency
Beer		
Wine		
Liquor or Spirits		

Caffeine

- None
- Coffee
- Soda
- Tea
- Energy Drinks
- Less than 2 per day
- 2-5 per day
- More than 5 per day

Intake:______

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Type	Started

Drug Use

- None
- Marijuana
- Intravenous Drugs/Illicit drugs

Type:______

Exercise

- None

Type	Quantity	Frequency
Yes		

Family Medical History

- [ ] No knowledge of family history

No family history of

- [ ] Autoimmune Disease
- [ ] Bleeding/Clotting
- [ ] GI Disorders
- [ ] GI malignancies
- [ ] Liver Disease

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Colon Polyps	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic
None

	Yes	No
HIV exposure		
persistent infections		
strong allergic reactions or urticaria		

Cardiovascular
None

	Yes	No
chest pain		
shortness of breath with exercise		
irregular heart beat		
shortness of breath when lying down		
palpitations		
swelling of legs		
passing out		

Constitutional
None

	Yes	No
tired		
fever		
loss of appetite		
tired or fatigued		
sweats		
weight gain		
weight loss		

ENMT
None

	Yes	No
difficulty swallowing		
dizziness		
ear pain		
nasal obstruction		
nose bleeds		
sore throat		
sores in mouth		

Endocrine
None

	Yes	No
excessive thirst		
hair loss		
heat intolerance		

Eyes
None

	Yes	No
double vision		
loss of vision		
light hurts eyes		

Gastrointestinal
None

	Yes	No
abdominal pain		
abdominal swelling		
change in bowel habits		
constipation		
diarrhea		
swallowing problems		
gas		
heartburn		
jaundice		
nausea		
rectal bleeding		
stomach cramps		
vomiting		
hemorrhoids		
rectal pain		

Genitourinary
None

	Yes	No
dark urine		
decrease in urine flow		
painful urination		
frequent urinary infections		
frequent urination		
blood in urine		
impotence		
waking up in night to urinate		
urethral discharge or incontinence		

Hematologic/Lymphatic
None

	Yes	No
bleeding gums or palpable lymph nodes		
easy bruising		
prolonged bleeding		

Integumentary
None

	Yes	No
allergies		
dryness		
hives		
itching		
jaundice		
lesions		
rashes		

Musculoskeletal
None

	Yes	No
arthritis		
back pain		
gout		
joint deformity		
joint pain		
muscle weakness		
stiffness		

Neurological
None

	Yes	No
dizziness		
fainting		
frequent headaches		
migraine		
numbness or tingling		
seizures		
tremors		
vertigo		

Psychiatric
None

	Yes	No
anxiety		
depression		
difficulty sleeping		
hallucinations		
nervousness		
panic attacks		
paranoia		

Respiratory
None

	Yes	No
asthma		
cough		
dyspnea		
excessive sputum		
coughing up blood		
shortness of breath with exercise		
wheezing		

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date

James Torosis, MD, FACP
Vicky Yang, MD
Daniel Rengstorff, MD
Cynthia Leung, MD
Virginia Morrow, MSN, ANP

Patient Information

Who referred you to this office?____________________Primary Care Physician________________________

First Name_________________________ Last Name_______________________ Middle Initial__________

Date of Birth _____/_____/______ □ Male □ Female Marital Status (circle one) S / M / W / D / DP

Spouse Name____________________________________

Address (street address) ____ Unit#____________________

City___________________________________State___________Zip Code________________________

1st Call Phone Number__________________(H/W/C) 2nd Call Phone Number__________________(H/W/C)

3rd Call Phone Number__________________(H/W/C) Email Address:______________________________

Employer Name_____________________________ Occupation/Title______________________________

***** Is it okay to leave messages regarding your treatment on your first call phone number? □ Yes □ No**

******* If NO can we leave a message on the second number above? □ Yes □ No**

EMERGENCY CONTACT INFORMATION

Name__________________________Relation_________________________Phone________________

INSURANCE INFORMATION

Primary SUBSCRIBER NAME:____________________________SUBSCRIBER DOB: ________________

SUBSCRIBER ID: ____________________________________

INSURANCE PLAN (i.e. Blue Cross, Blue Shield, Aetna, etc.): _______________________________________

PLAN TYPE: ☐ PPO ☐ HMO ***HMO NETWORK:** ☐ SPN ☐ PAMF ☐ Direct Network SM

☐ POS ☐ MED

PRE-CERTIFICATION PHONE NUMBER: ______________________

I request that payment of authorized insurance benefits be made to (the physician/supplier) for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim; if at the time of your service, you state you have had valid insurance coverage, but late determine, for whatever reason, you were not covered, you acknowledge and agree that you are responsible for the entire fee. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as coinsurance and the deductible are based upon the charge determination of the Medicare carrier. My signature authorizes releasing of the information to the insurance or agency shown.

__________________________________ ______________________

Signature of Patient **Date**

PENINSULA GI MEDICAL GROUP
OUR FINANCIAL POLICY

Thank you for choosing **Peninsula GI Medical Group** as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

**All Patients must complete a Patient Information Form before seeing the doctor.

Regarding Insurance:
As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time during treatment**. Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 business days, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and Master Card. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

**All co-pays are due at the time of treatment.

*****We DO NOT accept any Blue Cross Covered California or Health Net Covered California plans. If you have Blue Cross or Health Net insurance, it is your responsibility to know if it is through Covered California. If this is realized after your visit, you will be responsible for the entire cost of the visit.**

Missed Appointments:
Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 3 working days notice for cancellation of any procedures. **It is our policy to charge a $300.00 cancellation fee if given less than 72 hours notice. We will waive this fee if we are able to fill your procedure time; however, there is no guarantee that we will be able to do that in such a short amount of time.** If you are scheduled for an office appointment, we must receive a notice of cancellation at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. The charge for a late cancellation/no show procedure or appointment will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

Ancillary Services:
Please be aware that there may be a charge involved for ancillary services such as multiple telephone calls, extended telephone conversations, completing disability forms and/or forms related to your care, and drafting letters on your behalf.

Patient Balances:
If payment is not received within 30 days of the statement, a late fee will be applied to your balance as follows:

- Patient Balances of $0.01-$500.00 will incur a $10.00 late fee each month until payment is received
- Patient Balances greater than $500.00 will incur a $25.00 late fee each month until payment is received

Thank you for taking the time to review our Financial Policy. Please let us know if you have questions or concerns.

I have read and understand the Financial Policy in full.

____
Printed Name of Patient

______________________________ ______________________
Signature of Patient Date Signed

Acknowledgment of Receipt of Notice of Privacy Practices

Peninsula Gastroenterology Medical Group
2900 Whipple Avenue Suite 245, Redwood City, CA 94062
Privacy Officer Telephone Number 650-365-3700

I hereby acknowledge that I received or reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the patient waiting area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I authorize Peninsula Gastroenterology Medical Group to discuss my medical treatment with the following (i.e. spouse, friend, children. There is no need to list referring physicians):

NAME OF PERSON	RELATIONSHIP TO PATIENT
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Print **Your** Name: ______________________________________

Telephone: ______________________________________

Signature: ______________________________________ Date: ___________________

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

- ○ Parent or Guardian of Minor Patient
- ○ Guardian or Conservator of an incompetent Patient
- ○ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________________