DESERT GASTROENTEROLOGY ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT NAME:

ADDRESS (CITY, STATE, ZIP CODE):

DATE OF BIRTH: *I I* **GENDER: MALE** *I* **FEMALE** **SOCIAL SECURITY #:**

PHONE#: **CELL#:**

RACE: **ETHNICITY:**

CIRCLE ONE: SINGLE *I* **MARRIED** *I* **SEPERATED** *I* **DIVORCED** *I* **WIDOW** *I* **DOMESTIC PARTNER**

EMAIL ADDRESS:

EMPLOYER: **JOB TITLE:** **EMPLOYER#:**

EMERGENCY CONTACT NAME & RELATIONSHIP:

EMERGENCY CONTACT PHONE#: **CELL#:**

PHARMACY NAME: **PHONE#:**

PHARMACY CROSS STREETS:

SOCIAL SECURITY #:

PRIMARY INSURANCE:

ID#:

GROUP#:

INSURANCE MAILING ADDRESS:

INSURANCE PHONE#:

POLICY HOLDER :NAME: **POLICY HOLDER DOB:**

SECONDARY INSURANCE:

ID#:

GROUP#:

INSURANCE MAILING ADDRESS:

INSURANCE PHONE#:

POLICY HOLDER NAME: **POLICY HOLDER DOB:**

RELATIONSHIP TO PATIENT: **POLICY HOLDER SOCIAL SECURITY #:**

DESERT GASTROENTEROLOGY ASSOCIATES

PATIENT NAME: _____ **DOB:** _____

REASON FOR VISIT: _____

PATIENT MEDICATIONS

PLEASE LIST ALL CURRENT MEDICATIONS: ☐ *NOT TAKING ANY MEDICATIONS*

NAME OF MEDICATION	DOSAGE	FREQUENCY
	MG	
	MG	
	MG	
	MG	
	MG	
	MG	
	MG	
	MG	

PLEASE LIST ANY PREVIOUS ACID REFLUX MEDICATIONS YOU HAVE TAKEN: ☐ *NONE*

_____

PATIENT DRUG ALLERGIES

* **PLEASE ☒ ALL THAT APPLY:**

☐ *NO KNOWN DRUG ALLERGIES*

☐ ASPIRIN
☐ CIPRO
☐ CODEINE
☐ DEMEROL
☐ FENTANYL
☐ IBUPROFEN
☐ IV CONTRAST DYE
☐ MORPHINE
☐ PENICILLIN
☐ PROPOFOL/DIPRIVAN
☐ VERSED
☐ SULFA
☐ *OTHER DRUG ALLERGIES (please list below):*

_____

PATIENT SOCIAL HISTORY

ALCOHOL: ☐ I do NOT drink alcohol
☐ SOCIALLY
☐ DAILY
☐ CHRONICALLY
☐ QUIT

TOBACCO: ☐ I do NOT use tobacco
☐ SOCIALLY
☐ DAILY
☐ CHRONICALLY
☐ QUIT

RECREATIONAL DRUG:
☐ I have NEVER used drugs
☐ I have USED drugs in the PAST
TYPE: _____
☐ I am CURRENTLY using drugs
TYPE: _____

DO YOU EXERCISE? ☐ YES ☐ NO
MY COMPLIANCE WITH A HEALTHY DIET (CIRCLE ONE):
POOR FAIR GOOD EXCELLENT

SPECIAL DIET: ☐ YES ☐ NO

TYPE/RESTRICTIONS: _____

OTHER: BLOOD TRANSFUSIONS ☐ YES ☐ NO
EATING DISORDER ☐ YES ☐ NO
TATTOO(S) ☐ YES ☐ NO

OB/GYN:
CURRENTLY PREGNANT: ☐ YES ☐ NO
NUMBER OF PREGNANCIES: _____

IMMUNIZATIONS

☐ *NO IMMUNIZATIONS*	**DATE (month/year):**
☐ HEPATITIS – TYPE:	
☐ FLU SHOT	
☐ PNEUMONIA SHOT	

DESERT GASTROENTEROLOGY ASSOCIATES

PATIENT NAME: _____ **DOB:** _____

PATIENT SURGICAL PROCEDURE HISTORY

PLEASE ☒ ALL THAT APPLY

☐ *NO SURGICAL PROCEDURES DONE*

- ☐ Appendectomy (44950)
- ☐ Colon Resection(44140)
- ☐ Gastric Bypass (43846)
- ☐ Gallbladder removed (47562)
- ☐ Gastric resection (43631)
- ☐ Hernia (Hiatal / Inguinal / Umbilical) (39503/49520/49560)
- ☐ Hysterectomy (partial/total) (58180/58150)
- ☐ Lap Band (43843)
- ☐ Removal of Kidney (50340)
- ☐ Mastectomy (19301)
- ☐ Pacemaker (33206)
- ☐ OTHER SURGERIES: _____

PREVIOUS GI PROCEDURES: ☐ *NONE*

PLEASE ☒ ALL THAT APPLY:

TYPE:	*DATE:*
☐ Colonoscopy	
☐ EGD	
☐ ERCP	
☐ EUS	
☐ CT Liver Bx	

FAMILY MEDICAL HISTORY

☐ *UNKNOWN OR ADOPTED*

- ☐ FATHER: _____
- ☐ MOTHER: _____
- ☐ SISTER: _____
- ☐ BROTHER: _____
- ☐ GRANDFATHER: _____
- ☐ GRANDMOTHER: _____
- ☐ AUNTS: _____
- ☐ UNCLES: _____
- ☐ COUSINS: _____

PATIENT PAST MEDICAL HISTORY

PLEASE ☒ ALL THAT APPLY:

- ☐ *NONE*
- ☐ CANCER **TYPE:** _____
- ☐ ACID REFLUX/GERD
- ☐ ANEMIA
- ☐ ANXIETY/PANIC ATTACKS
- ☐ ARRHYTHMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BARRETT'S ESOPHAGUS
- ☐ CELIAC SPRUE
- ☐ CIRRHOSIS OF LIVER
- ☐ COLITIS **TYPE:** _____
- ☐ COLON POLYPS
- ☐ CONGESTIVE HEART FAILURE
- ☐ CORONARY ARTERY DISEASE
- ☐ CROHN'S DISEASE
- ☐ DEPRESSION
- ☐ DIABETES - **TYPE:** _____
- ☐ DIVERTICULITIS/DIVERTICULOSIS
- ☐ EMPHYSEMA
- ☐ ENDOMETRIOSIS
- ☐ ESOPHAGEAL STRICTURE
- ☐ FATTY LIVER
- ☐ FIBROMYALGIA
- ☐ GALLBLADDER DISEASE
- ☐ GLAUCOMA
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HELICOBACTER PYLORI (H.PYLORI)
- ☐ HEMOCHROMATOSIS
- ☐ HEPATITIS, AUTOIMMUNE
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ KIDNEY DISEASE
- ☐ LUPUS
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ OSTEOPOROSIS
- ☐ PANCREATITIS
- ☐ PSORIASIS
- ☐ SEIZURE DISORDER
- ☐ SLEEP APNEA
- ☐ STROKE/TIA
- ☐ THYROID - **TYPE:** _____
- ☐ TUBERCULOSIS (TB)
- ☐ ULCER
- ☐ OTHER: _____

DESERT GASTROENTEROLOGY ASSOCIATES

PATIENT NAME: _____ **DOB:** _____

PATIENT REVIEW OF SYMPTOMS

PLEASE ☒ ALL THAT CURRENTLY APPLY:

CONSTITUTIONAL:

- ☐ NONE
- ☐ CHILLS
- ☐ FATIGUE
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ WEIGHT CHANGE (GAIN/LOSS)
- ☐ OTHER: _____

GASTROINTESTINAL:

- ☐ NONE
- ☐ ABDOMINAL PAIN
- ☐ BLOATING/FLATULENCE
- ☐ BLOOD IN STOOL
- ☐ CHANGE IN BOWEL HABITS
- ☐ CONSITPATION
- ☐ DIFFICULTY SWALLOWING
- ☐ DARK STOOLS
- ☐ DIARRHEA
- ☐ HEARTBURN/REFLUX
- ☐ INCONTINENCE OF STOOL
- ☐ LOSS OF APPETITE
- ☐ NAUSEA
- ☐ VOMITING
- ☐ OTHER: _____

EYES:

- ☐ NONE
- ☐ CATARACTS
- ☐ GLASSES/CONTACTS
- ☐ GLAUCOMA
- ☐ VISION CHANGE
- ☐ OTHER: _____

EARS, NOSE,THROAT:

- ☐ NONE
- ☐ EAR ACHE
- ☐ HOARSENESS
- ☐ LOSS OF HEARING
- ☐ LOSS OF SMELL
- ☐ MOUTH SORES/ULCERS
- ☐ NASAL OBSTRUCTION
- ☐ NOSE BLEEDS
- ☐ POST NASAL DRAINAGE
- ☐ RECURRENT SINUS INFECTIONS
- ☐ RINGING IN EARS
- ☐ SORE THROAT
- ☐ OTHER: _____

SKIN:

- ☐ NONE
- ☐ ITCHING/HIVES
- ☐ JAUNDICE
- ☐ RASH
- ☐ SORES
- ☐ OTHER: _____

ENDOCRINE:

- ☐ NONE
- ☐ DRY SKIN
- ☐ COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ EXCESSIVE URINATION
- ☐ HEAT INTOLERANCE
- ☐ HOT FLASHES
- ☐ OTHER: _____

CARDIOVASCULAR:

- ☐ NONE
- ☐ AGINA/CHEST PAIN
- ☐ HEART MURMUR
- ☐ IRREGULAR HEARTBEAT
- ☐ PALPITATIONS
- ☐ RAPID HEART RATE
- ☐ SHORTNESS OF BREATH
- ☐ OTHER: _____

GENITOURINARY:

- ☐ NONE
- ☐ BLOOD IN URINE
- ☐ ENLARGED PROSTATE
- ☐ FREQUENT UTI
- ☐ URINATION BURN/PAIN
- ☐ URINARY FREQUENCY
- ☐ URINARY INCONTINENCE
- ☐ OTHER: _____

NEUROLOGICAL:

- ☐ NONE
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ HEADACHES
- ☐ MEMORY LOSS
- ☐ NUMBNESS/TINGLING
- ☐ SEIZURES
- ☐ STROKE
- ☐ TREMORS
- ☐ OTHER: _____

RESPIRATORY:

- ☐ NONE
- ☐ ASTHMA/ WHEEZING
- ☐ COUGH –FREQUENT
- ☐ SHORTNESS OF BREATH
- ☐ SLEEP APNEA
- ☐ OTHER: _____

HEMATOLOGIC&IMMUNOLOGIC:

- ☐ NONE
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ EASY BRUISING/ BLEEDING
- ☐ HIV EXPOSURE
- ☐ IMMUNE DEFICIENCY
- ☐ LYMPH NODE SWELL/PAIN
- ☐ PROLONGED BLEEDING
- ☐ SWOLLEN GLANDS
- ☐ THROMBOSIS/ BLOOD CLOTS
- ☐ OTHER:_____

MUSCULOSKELETAL:

- ☐ NONE
- ☐ ARTHRITIS
- ☐ NECK/BACK PAIN
- ☐ JOINT/MUSCLE WEAKNESS
- ☐ JOINT PAIN/SWELL/STIFFNESS
- ☐ MUSCLE PAIN/STIFFNESS
- ☐ OTHER: _____

PSYCHIATRIC:

☐ NONE ☐ ANXIETY ☐ BIPOLAR ☐ DEPRESSION ☐ SLEEPLESSNESS ☐ OTHER: _____

DESERT GASTROENTEROLOGY ASSOCIATES

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

❶ ***PATIENT INFORMATION:*** *I authorize the use or disclosure of the protected health information to be released from the record of:*

PATIENT NAME:	
DATE OF BIRTH: / /	**PHONE #:**
ADDRESS:	

❷ ***RELEASE OF RECORDS:*** *I authorize ALL of my protected health care information to be released to the following:*

NAME OF RECIPIENT(S)&RELATIONSHIP:
(SPOUSE, FAMILY MEMBER, ANOTHER DOCTOR, ETC)

DESERT GASTROENTEROLOGY ASSOCIATES
2510 WIGWAM PKWY #102 HENDERSON, NV 89074
PHONE: 702-255-5900 FAX#: 702-255-5980

FROM ⟺ TO _____
TO ⟺ FROM _____

❸ ***REQUEST:*** PLEASE FAX PATIENT'S [*INCLUDING: PROGRESS NOTES, LABS, RAD, OP REPORTS, AND PATHOLOGY*]

***FOR *OFFICE STAFF* TO COMPLETE:**

☐ **MOST RECENT MEDICAL RECORDS**
☐ **ENTIRE MEDICAL RECORD**
☐ **OTHER:** _____

⇨ ***Please fax requested records to:***
☐702-255-5980
☐702-255-6004

FOR THE PURPOSE OF: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information w/o the written consent of the patient is prohibited.

❹ **PROTECTED HEALTH INFORMATION, RE-DISCLOSURE, & RIGHT TO REVOKE AUTHORIZATION:**

I authorize Desert Gastroenterology Associates to use and/or disclose my health information which specifically identifies me or which can reasonably be used to carry out my treatment, payment, and healthcare operations. I hereby authorize the physician examining and/or treating me to release any medical condition and medical records concerning diagnosis and treatment when requested by third party (i.e. insurance company) for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released prior to revocation of this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires one year from date of signature.

❺ **I UNDERSTAND AND AUTHORIZE THIS RELEASE:** ➡ ***Signature of Patient*** _____

Date: _____

The above information and any attachments are confidential and privileged information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately at 702-255-5900 and destroy all copies of this message and any attachments. Thank you.

DESERT GASTROENTEROLOGY ASSOCIATES

OFFICE / FINANCIAL POLICIES AND PROCEDURES FOR DESERT GASTROENTEROLOGY ASSOCIATES

Dear Patient,

Welcome and Thank You for choosing Desert Gastroenterology Associates, Our staff is trying to provide the best medical care for *each* patient and we truly appreciate your time and patience.

APPOINTMENTS: ① A 24 hour notice must be given for all RESCHEDULED OR CANCELLED Appointments;
*Same Day Reschedule/Cancellation or No Show Appointments will incur a $25 fee (No exceptions).
*Please be advised that no-show charges are patient's responsibility and will not be billed to your insurance company.
② A copy of your insurance card and picture identification card is required.
③ If a referral/authorization is required, it is the responsibility of the patient to obtain the referral/authorization.
④ Messages/Questions for the Physician may take up to 24 hours for a response.
⑤ Patient results will NOT be given over the phone; A Follow up Appointment must be made w/the Physician
To Note: our office will forward the results to your Referring/Primary Care Physician per your request.
⑥ It is patient responsibility to inform our office of any changes with demographics, insurance coverage, medications, etc.

INSURANCE/FINANCIAL: ① Payment(s) for services are due at the time services are rendered (including co-pay or co-insurance).
*Accepted payments: cash and all major credit cards; we do not accept checks and apologize for any inconvenience.
② All fees incurred during medical treatment with Desert Gastroenterology Associates, including; co-payments, co-insurance, and yearly deductibles as determined by patient insurance carrier, is patient responsibility.
③ It is patient responsibility to inform our office of any changes with insurance coverage; Failure to do so could cause delay or denial of insurance payment.
④ In the event that your insurance has denied a claim, provide reduced benefits, or termed and the patient does not provide the insurance company with the information needed in a timely manner, it is patient responsibility for all fees incurred.
⑤ I hereby authorize the physician examining and/or treating me to release any medical condition and medical records concerning diagnosis and treatment when requested by third party (i.e. insurance company) for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
⑥ I hereby authorize insurance payment directly to Desert Gastroenterology Associates and associated Medical Providers including any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable for their services as described but not to exceed the reasonable and customary charge for these services.
⑦ If a collection agency's services are required, it is patient responsibility for all charges that may be assessed by the outside collection agency including but not limited to; agency fee, interest rates, attorney fees, court costs, and filing fees retained to pursue this matter.

PRESCRIPTION REFILLS: ① If you need a prescription re-fill, please have your pharmacy fax the request to our office at *(702) 255-5980.* Please allow ***72 hours*** for the request to be processed.
*Prescriptions can only be completed by the physician [Please do not ask staff to alter your medication(s)]

FORMS/LETTERS: ① FMLA, Disability, and Other Misc Forms may take ***7-10 Business Days*** for completion.
*NOTE: There is a mandatory ***$25 fee*** that is due at the time the forms are submitted to the office.
② Medical Records, Prior Authorizations, Referrals and Radiology Orders may take up to ***72 hours*** to process.

PAYMENTS: ① Please contact our billing department **MD ADMIN** with any billing questions you may have **PHONE#: 702-242-6911**

By signing below, I acknowledge that I have reviewed, understand, and will comply with the office policies and procedures explained above for Desert Gastroenterology Associates:

Date: _____

Signature of Patient: _____

Patient Name (Print): _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date