OCEANA
GASTROENTEROLOGY ASSOCIATES

PATIENT REGISTRATION FORM

Legal name ____
Last *First* *Middle*

Home Phone _______________ Work Phone __________________ Cell _______________

Home Address: ____

City _______________________ State ________________ Zip code __________________

Date of Birth ___________________S.S.# ______________ Sex: ☐ Male ☐ Female

EMERGENCY CONTACT:

Name ___________________ Relationship __________________ Phone _______________

HIPPA PERSONAL HEALTH INFORMATION DISCLOSURE

I choose to designate the individuals listed below as my primary contacts. Oceana Gastroenterology may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Name __________________ Relationship ______________ Phone ____________________

MESSAGES:

Please call [ ] home [ ] work [ ] cell phone

If unable to reach me: [ ] you my leave a detailed message [ ] please leave me a message to call back

Signature ____________________________________ Date ___________________________
(Patient, parent, authorized representative)

_ _

INSURANCE INFORMATION

Patient's relationship to the insured person: ☐ Self ☐ Spouse ☐ Child ☐ Other

If other than "self" please provide the following information:

Insured person

____
Last *First* *Middle*

Home Address: ____

City _______________________ State ________________ Zip code __________________

Home Phone __________________________ Work Phone___________________________

Date of Birth ___________________S.S.# ______________ Sex: ☐ Male ☐ Female

PRIMARY INSURANCE

Insurance Plan Name __________________

Group or Policy Number _______________

Insured's ID Number __________________

SECONDARY INSURANCE

Insurance Plan Name _______________

Group or Policy Number ____________

Insured's ID Number _______________

Patient Interview Form

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

Ethnicity
□ Hispanic or Latino □ Not Hispanic or Latino □ Patient declines to specify

Preferred Language
□ English □ Patient declines to specify

Contact Preference
□ Phone □ Email □ Patient decline to specify Other: _____

Pharmacy

_____
Name Address Phone

Allergies

□ Patient has no known allergies □ Patient has no known drug allergies

□ Adhesive tape □ Codeine Sulfate □ Erythromycin □ Penicillins □ Shellfish
□ Iv Dye, Iodine Containing □ Latex gloves

Current Medications

□ None

Name	Dose	How taken?

Immunizations

□ None

□ Flu vaccine When:_____ □ Hep A When:_____ □ Hep B When:_____ □ Pneumovax When:_____ □ TB skin test When:_____

Diagnostic Studies/Tests

□ None

□ Colonoscopy When:_____ □ EGD When:_____ □ CT Abdomen/Pelvis When:_____ □ MRI Abdomen/Pelvis When:_____ □ ERCP When:_____

Previous Procedures

□ None

□ Gallbladder removed □ Appendectomy □ Colon resection □ Small Bowel Resection □ Exploratory Laparoscopy

□ Gastric Bypass □ Gastric Lap Band □ Hemorrhoidectomy □ Hemorrhoid banding □ Abdominoplasty

□ Hysterectomy-Abdominal □ Bilateral Tubal Ligation (BTL) □ Mastectomy R Breast □ Pacemaker Insertion □ Defibrillator Placement

□ Coronary Artery Bypass Graft (CABG) □ Abdominal aortic aneurysm (AAA) repair □ Heart valve replacement □ Cardiac Cath-with stent placement □ Joint Replacement

□ Back Surgery □ Fibromyalgia Other:_____ Other:_____

Past or Present Medical Conditions

□ None

Gastroenterology/Hepatology

□ Colon polyp history □ Colon cancer □ Irritable Bowel Syndrome □ Diverticulitis

□ Crohn's Disease □ Ulcerative Colitis

□ Gastroesophageal Reflux Disease (GERD)

□ Barrett's Esophagus

□ Ulcer Disease □ Hepatitis B □ Hepatitis C □ Fatty Liver

□ Cirrhosis □ Celiac Disease □ Bowel Obstruction

□ Pancreatitis

□ Anemia Other:_____ Other:_____

Cardiology

□ Coronary Artery Disease □ Congestive Heart Failure

□ Heart Attack □ High blood pressure

□ Atrial Fibrillation □ Vascular Disease □ High Cholesterol □ Stroke

□ Transient Ischemic Attack □ Valvular heart disease

□ Pacemaker □ Coronary Artery Stents

Other:_____ Other:_____

Pulmonology □ C.O.P.D. □ Asthma □ Sleep apnea □ Blood Clots (leg)
□ Blood Clots (lung) □ Wheezing Other:_____
Other:_____

Other □ Anxiety disorder □ Arthritis □ Bipolar disorder □ Body piercings
□ Breast cancer □ Current pregnancy □ Depression □ Diabetes Mellitus, Insulin Dependent (Type 1)
□ Diabetes Mellitus, Non-Insulin Dependent (Type 2) □ Fibrositis/ Fibromyalgia □ Gout □ HIV exposure
□ HIV Infection □ Hypothyroidism □ Kidney disease □ Kidney stones
□ Lung cancer □ Ovarian Cancer □ Prostate Cancer □ Skin Cancer
□ Seizures □ Tattoos

Social History
Occupation:_____ Number of Children:_____

Marital Status
□ Single □ Married □ Divorced □ Separated □ Widowed
□ Civil Union □ Unknown □ Other

Alcohol
□ None
□ Occasionally □ Daily

Caffeine
□ None
□ Occasionally □ Daily

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	Quit	Quantity	Frequency
□ Cigarettes				
□ Cigar				
□ Chewing Tobacco				

Drug Use
□ None

Type	Quantity	Number	Frequency
□ IV or intranasal drugs			Times / month
□ Recreational			Times / month

Exercise
□ None
□ Regular exercise □ Occasional exercise

Family Medical History
□ No knowledge of family history

No family history of

□ Celiac sprue □ Colon cancer
□ Colon polyps □ Crohn's disease
□ Ulcerative Colitis / IBD □ Stomach cancer

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth	□	□	□	□	□	□
Healthy	□	□	□	□	□	□
Ill	□	□	□	□	□	□
Seriously Ill	□	□	□	□	□	□
Disabled	□	□	□	□	□	□
In Remission	□	□	□	□	□	□
Alive	□	□	□	□	□	□
Deceased/At Age	□_____	□_____	□_____	□_____	□_____	□_____
Cause of Death	_____	_____	_____	_____	_____	_____

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Celiac Disease	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□
Colon polyps	□	□	□	□	□	□
Crohn's disease	□	□	□	□	□	□
Gallbladder disease	□	□	□	□	□	□
Liver disease	□	□	□	□	□	□
Ulcerative colitis	□	□	□	□	□	□
Other:	□	□	□	□	□	□

Review Of Systems

Allergic/Immunologic

□ None	Y	N
HIV exposure	□	□
Persistent infections	□	□
strong allergic reactions or urticaria	□	□

Cardiovascular

□ None	Y	N
chest pain	□	□
dyspnea with exercise	□	□
irregular heart beat	□	□

orthopnea	□	□
Palpitations	□	□
peripheral edema	□	□
syncope	□	□

Constitutional

□ None	Y	N
fatigue	□	□
fever	□	□
loss of appetite	□	□
malaise	□	□
sweats	□	□
weight gain	□	□
weight loss	□	□

ENMT

□ None	Y	N
difficulty swallowing	□	□
dizziness	□	□
ear pain	□	□
nasal obstruction	□	□
nose bleeds	□	□
sore throat	□	□
hearing loss	□	□

Endocrine

□ None	Y	N
excessive thirst	□	□
hair loss	□	□
heat intolerance	□	□

Eyes

□ None	Y	N
double vision	□	□
loss of vision	□	□
photophobia	□	□

Gastrointestinal

□ None	Y	N
abdominal pain	□	□
abdominal swelling	□	□
change in bowel habits	□	□
Constipation	□	□
diarrhea	□	□
gas	□	□
heartburn	□	□

jaundice	□	□
nausea	□	□
rectal bleeding	□	□
stomach cramps	□	□
vomiting	□	□
difficulty swallowing	□	□

Genitourinary

□ None	Y	N
dark urine	□	□
decrease in urine flow	□	□
dysuria	□	□
frequent urinary infections	□	□
frequent urination	□	□
hematuria	□	□
Impotence	□	□
nocturia	□	□
urethral discharge or incontinence	□	□

Hematologic/Lymphatic

□ None	Y	N
bleeding gums or palpable lymph nodes	□	□
easy bruising	□	□
prolonged bleeding	□	□

Integumentary

□ None	Y	N
Allergies	□	□
dryness	□	□
Hives	□	□
itching	□	□
jaundice	□	□
lesions	□	□
rashes	□	□

Musculoskeletal

□ None	Y	N
arthritis	□	□
back pain	□	□
Gout	□	□
Joint deformity	□	□
Joint pain	□	□
muscle weakness	□	□
stiffness	□	□

Neurological

□ None	Y	N
dizziness	□	□
fainting	□	□
frequent headaches	□	□
Migraine	□	□
numbness or tingling	□	□
Seizures	□	□
tremors	□	□
vertigo	□	□
memory loss	□	□

Psychiatric

□ None	Y	N
anxiety	□	□
Depression	□	□
difficulty sleeping	□	□
Hallucinations	□	□
Nervousness	□	□
panic attacks	□	□
paranoia	□	□

Respiratory

□ None	Y	N
asthma	□	□
cough	□	□
dyspnea	□	□
excessive sputum	□	□
coughing up blood	□	□
shortness of breath with exercise	□	□
wheezing	□	□

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 **Date**

OCEANA GASTROENTEROLOGY ASSOCIATES

Office Policies

We would like to thank you for choosing OCEANA GASTROENTEROLOGY ASSOCIATES as your medical provider. We have written this policy to keep you informed of our current office policies.

Office Hours: Our clinic is open Monday - Friday, 8:00 a.m. - 5:00 p.m.

Appointments: We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness.

After Hours and Emergencies: For a serious emergency call 911 right away. To page the provider please leave a message on option 5.

Urgent Need or Sudden Illness: We have a limited number of same day or "work-in" appointments available every day. Please call early in the day, as these spots fill up quickly. If there are no available appointments with your physician, the receptionist will offer an appointment with the physician assistant or transfer you to the medical assistant who will discuss your needs with a physician and determine what you should do.

Cancellations: Please call within 48 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. There will be a charge of $30 for appointment **no-show.**

PROCEDURE CANCELLATIONS: Any cancellations or reschedules for your procedures must be made at least 7 days prior to the procedure date **with our office. There will be a $250 fee for procedure NO SHOWS.**

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

Nurse Call: What is a "nurse call"? This is what we say when someone comes into the office and asks for samples, wants to leave a form to be filled out, has a question, but doesn't have an appointment. The receptionist will ask you to sign in and will notify the medical assistant that you are here. The medical assistant will come to talk with you as soon as she can. Remember that scheduled appointments take priority over walk-ins, so you may have a bit of a wait. We recommend that you call first.

Test Results: If you have diagnostic testing, i.e., lab, x-ray, echo, ultrasound, please schedule a follow-up appointment, within 2 WEEKs, to go over the results with your physician. You will be subject to your copay/coinsurance for the follow-up appointment. Results will not be given over the phone.

Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.
- If you need to call for refills, don't wait until you have run out. Most refills require the doctor's approval. If your doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
- Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready.
- Some medications have potential side effects that must be monitored. We require check-ups every 3 or 4 months for these medications. Be sure to keep those follow-up appointments.
- Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.

Please note some special medication require a prior authorization. Please make sure you contact our office 2 weeks prior to your last dose so we can work on requesting refill authorization that might take time.

Samples: We sometimes offer you samples to help you try out a new medication before you purchase it. Remember that samples are not a long term way to fill your prescription. We do not always have samples of your medications.

Please do not rely on samples for medications you take long term.

Narcotics: We do not prescribe narcotics for chronic use. If you require use of narcotics, our physicians will refer you to a pain management specialist.

Referrals: Referrals are handled by our Referral Department. Sometimes this can be done on the same day as your appointment and sometimes it can take SEVERAL days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.

As a patient, it is your responsibility to ensure that your specialist is on your plan. It is also your responsibility to ensure your specialist receives your test results. Please understand that it can sometimes take a few weeks to get an appointment with a specialist. This is not something we have control over.

Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won't follow physician instructions about an important health issue
- Abusive to staff.
- Failure to pay your bill

Please note that this list is not exhaustive and the Office may dismiss you for a reason not listed above.

Dismissal Process:

We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, we will do our best to work out a payment plan with you.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits.

As a courtesy to our patients we will file primary insurance forms from our office. We do not file secondary insurance except for Medicare Recipients. In order to do this we will require information from you. We will need all your demographic and insurance information prior to your appointment. We will also request an update on this information approximately every six months thereafter. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other forms that will assist in making sure that your claim is filed correctly.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard). Payments are also accepted by phone.

Auto Accident: If your injury is a result of an auto accident, you are required to pay for services and then collect from the auto carrier. We will not file your insurance but will provide you with a receipt to do so.

Liability Injury: If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance but will provide you with a receipt to do so.

Return Checks: There will be a $45.00 fee for any returned checks.

Disability, Insurance Forms. Attending Physician Statements: AS OF 04/01/2015 THIS OFFICE NO LONGER FILLS OR FILES DISABILITY FORMS. There will be a charge of $15.00 for the completion of a **SIMPLE** medical forms or you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 7-10 days for the completion of these forms. **We do not mail these forms.**

Medical Records: We will provide you a copy of your medical records upon request, there will be a $35 processing and print fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

There WILL BE A $35.00 CHARGE FOR MEDICAL RECORD REQUEST OR $1 Per PAGE FOR RECORDS LESS THAN 10 PAGES.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Accounts that are not paid within 60 days begin our in house collection process. If your balance becomes 65 days overdue, your doctor will be notified and you may be subject to dismissal from the practice.

Acknowledgement

I acknowledge that I have received and read a copy of the **OCEANA GASTROENTEROLOGY ASSOCIATES Office Policies** and agree to abide by the rules set forth herein.

I understand and agree to the no-show fees for appointment and procedure cancellations.

_____

Patient Name: Signature/Patient or Guardian Date

A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST.

OCEANA GASTROENTEROLOGY ASSOCIATES

2097 COMPTON AVE. SUITE #103 CORONA CA 92881
PH-951-934-0505 FAX-951-934-0506

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a “partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Patient Signature	Date	Physician Signature

OCEANA GASTROENTEROLOGY ASSOCIATES

2097 COMPTON AVE. SUITE#103, CORONA CA 92881

PH: 951-934-0505, FAX: 951-934-0506

- I hereby acknowledge that I received a copy of any amended Notice of Privacy Practices. I further acknowledge that a copy of the current notice of privacy practice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor parent
- Guardian or conservator of an incompetent patient

Name and Address of Patient:
_____
_____
_____

- Estoy dando conocimiento de recibir copia de Notificacion de Practica Privada. Ademas, reconozco que una copia del aviso actual sera fijada en la zona de recepcion, y que una copia de la Notificacion de Practicas Privacidad modificado estara disponible en cada cita.

Firmado: _____ Fecha: _____
Imprimir Nombre: _____ Telefono: _____

Si no esta firmada por el paciente, por favor indique la relacion:

- El Padre o tutor del paciente menor de edad
- Tutor o curador de un paciente incompetente, Nombre y direccion del paciente:

_____
_____