Philip Yee MD

BASS Medical Group ***Gastroenterology***

REGISTRATION FORM

PATIENT INFORMATION

Name: Last First Middle

Birth Date: **Gender:** Male Female **Marital Status:**

information required by US Dept of Health & Human Svc. CMS mandate: **Language:**

Race: **Ethnicity:**

SSN: **Driver's License No:** **Referring Doctor:**

Address: City State Zip

Home phone: **Cell phone:**

Employer Name:

SPOUSE/PARENT INFORMATION

Name: Last First Middle

Birth Date: **Relationship:** **SSN:**

Home phone: **Cell phone:**

EMERGENCY CONTACT INFORMATION

Name: Last First **Relationship:**

Contact phone:

INSURANCE INFORMATION

Primary Insurance: **Insurance phone:**

Insurance Policy #: PPO HMO

Subscriber Name: **Relationship to patient:**

Secondary Insurance: **Insurance phone:**

Insurance Policy #: PPO HMO

Subscriber Name: **Relationship to patient:**

Subscriber SSN:

HEALTH QUESTIONAIRE

Reason for office visit:

Height: Weight:

Allergies: *drug & reaction:*

no drug allergy

Medications: Current Medication taken: **none**

name of medication *dose* *# of times taken per day*

Medical History:

Please mark all applicable box(es) below .

Asthma	Diverticulosis	Shortness of breath	Nausea
Heart trouble	Colon polyp	Chest pain	Rectal pain
High blood pressure	Kidney trouble	Leg swelling	Vomiting
Heart murmur	Anemia	Palpitations	Dysuria
Arrhythmia	Thyroid disease	Abdominal distention	Arthralgias
Ulcers	Diabetes	Abdominal pain	Back pain
Gall bladder disease	Weight change	Anal bleeding	Rash
Liver disease	Trouble swallowing	Blood in stool	Headache
Pancreas disease	Apnea	Constipation	Seizures
Colitis or Crohns disease	Cough	Diarrhea	Bruises/ bleed easily

Past Illness: Prior Surgery/ Hospitalization/ Endoscopy /Biopsy: **none**

2. Family History: *please list details...* Mother: well / Father: well /

GI disorders (cancer, polyp, liver, colon, stomach, etc)

other

3. Social / Personal History:

Drinking alcohol: no yes - drinks per week: last pneumovax?

Smoking: current - pack per week: never former last flu vaccine?

Occupation: Drug use: no yes Sexually active: no yes

I agree to the HIPAA policy and office policies and I am financially responsible for all charges for services to me, including balance remaining after payment of possible insurance benefits and for services not covered by my insurance.
I authorize payment of medical benefits to myself or the names provided for professional services rendered.
I authorize the release of any medical information necessary to process this claim.

I request that medical information may be left at my telephone voice mail. yes - Telephone #:
no

Signature : ______________________________ Date : ___________

Print Name if not patient, state relationship:

Due to HIPAA rules we cannot accept electronic transfer of information at this time.
Please print, sign and fax to 925-275-1814. Thank you.

Philip Yee MD BASS Medical Group

Gastroenterology

5401 Norris Canyon Road, Suite 208 San Ramon CA 94583
1022 Murrieta Blvd Livermore, CA 94550

telephone (925) 275-1811 fax (925) 275-1814 *www.gidoctor.org*

NO SHOW/ LATE CANCELLATION POLICY

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A “no show” is missing a scheduled appointment. A “late cancellation” is canceling an appointment without calling us to cancel 24 business hours in advance of an office visit or 48 business hours in advance of a procedure.

A charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than <u>24 business hours</u> notice is given.

A charge of $200.00 will be assessed for each no show or late cancellation procedure appointment if less than <u>48 business hours</u> notice is given.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Signature : ______________________________ Date : __________

Print Name

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PATIENT RECORDS ACCESS FORM

I, , with DOB,

Print Patient's full name

hereby consent and authorize

Name(s) of Family Member(s) *Relationship to patient*

to have full access to ALL of my medical records.

I understand that:

· I do not have to give my permission to share these records.
· I may revoke this authorization at anytime by giving written notice to the office.

Signature : ____________________________ Date : __________

Patient's name