Philip Yee MD Inc BASS Medical Group Gastroenterology

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REGISTRATION FORM

PATIENT INFORMATION

*... * marks required fields ...*

Name: Last* First * Middle

Birth Date* Sex ○ male ○ female

Marital Status --select--

Language --select-- Race Decline to Answer Ethnicity Decline to Answer

SSN

Drivers License No

Referring Provider

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:

Policy #: HMO PPO

Subscriber Name: relationship to patient:

Secondary Insurance: insurance phone:

Policy #: HMO PPO

Subscriber Name: relationship to patient:

Subscriber SSN:

HEALTH QUESTIONAIRE

Reason for office visit:

Weight: lbs.

Height : ft. in.

Current Medical History:

*please **mark [-/]** as applicable below: all unmarked boxes will be assessed as "no"*

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 Crohn's disease	☐	Cough	☐	Diarrhea	☐	Bruises or Bleeding	☐

Prior Medical History Information:

Allergies no known drug allergy N/A

Medications: no medication taken N/A

Past Medical History

Past Surgical History

Family History

- select if present in family history:

ulcer ☐
gall stone ☐
colon polyp ☐
colitis ☐
colon cancer ☐
pancreas cancer ☐
liver cancer ☐
stomach cancer ☐

Smoking: --select-- amount per week: Smokeless Tobacco: --select--

Alcohol: --select-- amount per week:

Substance/ Drug use: --select--

Sexually active: --select--

last pneumovax last flu vaccine

Occupation:

Information requested:

Identification Card
Insurance Card- Front & Back *- please send copies to us*
Records requested for review

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 by voice mail: O yes O no by texting: O yes O no telephone #:

I request that medical information may be sent by email: O yes O no email address:

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 24 business hours notice is given.
A charge of $200.00 will be assessed for each no show or late cancellation procedure appointment if less than 48 business hours 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. This policy has been established to help us serve you better.

Colonoscopy Charges

Please be aware that while a "screening" colonoscopy is typically covered at 100%, should a polyp be removed or a biopsy taken, your insurance company will then change the coverage to "diagnostic", therefore possibly negating the 100% coverage. Similarly, if a patient presents with symptoms, the insurance company will not consider the procedure to be a "screening".

- A patient must be 50 years or older in most cases for the procedure to be screening/ preventative.
- If your colonoscopy is paid as preventative, a subsequent screening procedure must be on or after the 10 year anniversary date.
- If a patient is having a colonoscopy within a 3-5 year interval due to a history of polyps, this is considered as diagnostic/ surveillance and not screening/ preventative, which may be reflected in your liability portion of your plan coverage.
- It is important for the patient to understand that, in addition to the procedure fee, there may also be an anesthesiology fee, facility fee and laboratory fee if any specimen is sent for pathology review.

If there is anything you are not sure about, it is appropriate to call your insurance company prior to the procedure, They may be able to help calculate how much you will be responsible for, should anything be found during the procedure. This can help you to avoid any surprises.

PATIENT RECORDS ACCESS

I hereby consent and authorize

Name(s) of Family Member(s)/ other: _____ 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: *... signature must be completed for submission*

completed by: _____ relationship (if not the patient) _____

When completed, please print and fax to us at (925) 275-1814 with signature on form.

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