Philip Yee MD

Valley Digestive Care ***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:** --select one-

Race: --select one-- **Ethnicity:** --select one--

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

Address: City State

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 QUESTIONNAIRE

Reason for office visit:

1. History of Past Illness: Prior Surgery/ Hospitalization: ○ none

Current Medication taken: ○ none

name of medication dose # of times taken per day

2. Family History: *please list details...*

☐ GI disorders (cancer, polyp, etc)

☐ other

3. Social / Personal History:

Drinking alcohol: ○ never ○ rarely ○ moderately

Smoking: ○ never ○ previously smoked ○ presently smoking

Occupation:

last pneumovax?

last flu vaccine?

Allergies: *drug & reaction:*

☐ *no drug allergy*

4. System Review:

Height: ft. in. Weight: lbs.

Please mark all applicable box(es) below .

- ☐ weight change
- ☐ trouble swallowing
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ ulcers
- ☐ Abdominal pain
- ☐ Gall bladder disease
- ☐ Liver disease
- ☐ Pancreas disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis or Crohns disease
- ☐ Diverticulosis
- ☐ Colon polyp
- ☐ Changed bowel habits
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Anal fissure or fistula
- ☐ Skin disease
- ☐ Cough
- ☐ Asthma
- ☐ Headache
- ☐ Arrhythmia
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Heart murmur:
- ☐ Valvular heart disease
- ☐ Burning urination
- ☐ Kidney trouble
- ☐ Arthritis
- ☐ Back pain
- ☐ Seizures
- ☐ Anemia
- ☐ Thyroid disease
- ☐ High cholesterol
- ☐ Diabetes

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 canot accept electronic transfer of information at this time.
Please print, sign and fax to 925-275-1814. Thank you.