Appointment Date: _____ *Time:* _____

NORTH COUNTY GASTROENTEROLOGY MEDICAL GROUP, INC.
3923 Waring Road, Suite A • Oceanside, CA 92056-4499
(760) 724-8782 • Fax (760) 842-7801
www.ncgastro.com

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This appointment is for an Office Visit, not a procedure. *Please bring your forms with you to your appointment*.

Information Forms

Welcome to the office of North County Gastroenterology Medical Group, Inc. We are located near the Tri City Medical Center in Oceanside, CA. You may call us at the above number if you need detailed directions.

Our appointment times are very limited. With our backlog of patients needing appointments, we believe it is not fair to other patients when an appointment time goes unused.

Please read and complete the enclosed forms. It is very important that they be completed and brought with you to your appointment.

1.) **MEDICAL HISTORY**
2.) **MEDICATION & ALLERGY LIST** (On the medication list please list the name of the drug, the strength, and how you are taking the drug. Please include any vitamins or dietary supplements that you are taking and list the type of allergic reaction you have to a medication, i.e. rash, itching, swelling etc.)
3.) **PATIENT INFORMATION FORM** (Please provide an email address for our portal. All normal results will be reported to you via the portal).
4.) **PATIENT FINANCIAL RESPONSIBILITY FORM**

Before making the trip to the office, please remember the following:

1. We need you to bring your completed forms noted above.
2. For scanning and security purposes, we need your actual insurance card(s) and a photo ID. Be prepared to pay any insurance co-payments.
3. Please arrive at the office 15 minutes prior to your scheduled appointment to complete the check-in process.
4. If you arrive late (after your scheduled appointment time), your appointment may be rescheduled.

INSURANCE INFORMATION: As a courtesy to you and per any contractual agreement with your insurance, we will file claims with your primary and secondary insurance carriers only, provided you have given us all necessary information (i.e. current insurance cards and correct billing address). If you have more than two policies, you are responsible for filing claims with a third and any subsequent insurance carriers.

Co-pays are collected for each visit at check-in. Office visit co-pays will be collected at time of check-in. We accept cash, checks, or credit cards (please be aware that we cannot break $100 bills).

Please be advised we have a $25.00 fee you will be charged for any returned checks.

FINANCIAL RESPONSIBILITY: Please refer to the "Patient Financial Responsibility Form". See #1. Financial Responsibility.

North County Gastroenterology Medical Group, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

North County Gastroenterology Medical Group, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen, nacional, edad, discapacidad, o sexo.

PATIENT INFORMATION FORM

WELCOME TO NORTH COUNTY GASTROENTEROLOGY

Please use black ink. Date: _____

PATIENT NAME: _____ Acct#_____

MALE _____ FEMALE _____ AGE _____ DATE OF BIRTH _____ MARITAL STATUS: S M W D

ADDRESS: _____

Please circle one: Apt. Unit Space #_____ City: _____ State: _____ Zip: _____

HOME PHONE: ( ) _____CELL: ( )_____ E-MAIL_____

Preferred contact number ***(please circle one):*** Home Cell Work Preferred Language: _____

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian
☐ Native Hawaiian/other Pacific Islander ☐ Unknown
☐ American Indian/Alaska Native ☐ Decline to provide

Ethnicity: ☐ Hispanic/Latino
☐ Non-Hispanic/Latino
☐ Decline to provide

EMPLOYER: _____ ADDRESS: _____

OCCUPATION: _____ WORK PHONE: ( ) _____

SS #: _____ DRIVER'S LICENSE #: _____ STATE: _____

SPOUSE OR RESPONSIBLE PARTY: _____ DOB: _____

SS #: _____ EMPLOYER: _____

WORK PHONE: ( ) _____HOME PHONE (*if different)*: _____

PERSON TO NOTIFY IN EMERGENCY: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: ( ) _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

WHO REFERRED YOU TO OUR OFFICE? _____

INSURANCE INFORMATION

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it and their **CORRECT** billing address). **HMO co-pays are collected for each visit at check-in**. **A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

	PRIMARY	**SECONDARY**
Insurance Name:	_____	_____
Claims address:	_____	_____
	_____	_____
Policyholder Name:	_____	_____
Policyholder DOB:	_____	_____
Policyholder ID:	_____	_____
Group ID or #:	_____	_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: X_____

For billing purposes, we require this form to be fully completed. We reserve the right to reschedule any appointments due to incomplete forms or tardiness. Please let us know within 48 hours if you are unable to keep your appointment.

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name:_____Date:_____

The physicians of North County Gastroenterology Medical Group, Inc. require this form to be signed by our patients. We appreciate your cooperation.

If you have ANY questions, please ask the receptionist.

FINANCIAL RESPONSIBILITY (3 Scenarios):

1. If I have no insurance I understand that I will be personally responsible for any medical fees I will incur with North County Gastroenterology Medical Group, Inc.

OR

2. If I have an HMO or coverage by a State or Federally funded program with which North County Gastroenterology Medical Group, Inc. is contracted, I agree that I will be responsible for any charges incurred if I DO NOT provide my most current and correct insurance to the office at the time of my services. I understand I will need a current authorization for my services from my Medical Group.

OR

3. If I have insurance I understand I will be personally responsible for any deductibles, coinsurance or co-pays that my insurance coverage determines. I agree to furnish up-to-date insurance information and a current insurance card whenever having services in the office.

I have read and agree to the terms above that apply to me.

Signature of Patient or Legal Guardian: X_____

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION:

I HEREBY AUTHORIZE North County Gastroenterology Medical Group, Inc. to release or obtain medical information acquired in the course of my examination or treatment, to or from my insurance company, or other physicians required to participate in my care or for the purpose of processing my claim.

Signature of Patient or Legal Guardian: X_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment for medical services provided directly to the North County Gastroenterology Medical Group, Inc. physicians.

Signature of Insured or Patient: X_____

AUTHORIZATION TO LEAVE MEDICAL INFORMATION:

It is our policy to leave medical information, such as normal blood test results, normal biopsy results on your answering machine, or with someone residing at your home. By signing below, I agree with this policy, otherwise speak with the receptionist.

Signature of Patient or Legal Guardian: X_____

Below: To be signed the day of your appointment:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY:

I acknowledge that I have received a copy of North County Gastroenterology Medical Group's Privacy Policy.

Date: _____ ***Signature of Patient or Legal Guardian***: **X**_____

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TRI-CITY GASTROENTEROLOGY MEDICAL GROUP, INC.

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NAME: _____ **PRIMARY DOCTOR:**_____

DATE OF BIRTH: _____ **AGE:** _____ **REFERRING DOCTOR:**_____

CHIEF COMPLAINT: _____

PHYSICIAN'S COMMENTS (HPI):

Do you have a pacemaker or a defibrillator? (If yes, we need to copy your card) ___ **yes** ___ **no**
Are you taking any blood thinners? Aspirin, Plavix, Coumadin, etc ___ **yes** ___ **no**

Have you ever seen a stomach, colon, or liver specialist: (Gastroenterologist)? ___ **yes** ___ **no**
If yes, name of Doctor:_____

Have you ever had any of the following tests?	**YES**	**NO**
Colonoscopy or Sigmoidoscopy		
Upper endoscopy (EGD)		
CT scan of your abdomen		
Stomach xray (upper GI)		
Gallbladder ultrasound		

Have you ever had any of the following medical problems?	**YES**	**NO**
Colon polyps		
Colon cancer		
Colitis		
Diverticulitis		
Ulcers		
Liver problems		
Gallstones		
Pancreatitis		

Are you currently experiencing any of the following problems?	**YES**	**NO**
Abdominal pain		
Heartburn		
Bloating		
Nausea		
Vomiting		
Trouble swallowing or food getting stuck		
Change in bowel habits		
Constipation: hard stools		
Constipation: infrequent stools		
Diarrhea		
Black stools		
Rectal bleeding		
Yellowness of skin or eyes (Jaundice)		
Weight loss (unintentional)		
Milk causes gas		
Milk causes diarrhea		
Wheat causes digestive problems		

Continued on other side/next page

REVIEW OF SYSTEMS: If you are experiencing any of the problems listed below, **please circle them**.

ALLERGIC/IMMUNOLOGIC	Persistent infections	Allergic reactions
CARDIOVASCULAR	Chest pain	Dyspnea with exercise
CONSTITUTIONAL	Fatigue	Fevers
ENMT	Nose bleeds	Sore throat
ENDOCRINE	Cold intolerance	Heat intolerance
EYES	Double vision	Loss of vision
GENITOURINARY	Dysuria	Hematuria
HEMATOLOGIC	Easy bruising	Prolonged bleeding
SKIN	Jaundice	Rashes
MUSCULOSKELETAL	Joint pain	Muscle weakness
NEUROLOGICAL	Frequent headaches	Seizures
PSYCHIATRIC	Anxiety	Depression
RESPIRATORY	Asthma	Cough

LIST ALL MEDICAL PROBLEMS (PAST AND PRESENT)

DATE	MEDICAL PROBLEMS

LIST ALL SURGERIES

DATE	SURGERIES

FAMILY HISTORY

Have any relatives ever had any of the following diseases? Indicate *relationship* and *age* at time of diagnosis.	**YES**	**NO**
Esophageal Cancer		
Stomach Cancer		
Colon Cancer		
Colon Polyps		
Ulcerative Colitis		
Crohn's Disease		
Other Cancers		

SOCIAL HISTORY

How much alcohol do you drink?

_____ per day or

_____ per week

Tobacco? _____YES _____NO
How much? _____ packs per day
How long? _____ years
If quit, when did you stop? _____

Recreational drugs or marijuana?
_____YES _____NO

Marital Status: S M D W

Current or previous profession?

Caffeine: _____ cups per day

NORTH COUNTY GASTROENTEROLOGY MEDICAL GROUP, INC.

MEDICATION & ALLERGY LIST

Patient name: _____

Your Pharmacy:_____**Pharmacy address**:_____

Pharmacy phone number:_____

Do you have a pacemaker or a defibrillator?_____ If yes, please bring your card with you.

It is very important that you bring this completed list to your appointment.

List all medications you are taking by name, the strength of each dose and how often you take it. Include hormones, diet pills, vitamins, cold tablets and over the counter laxatives, herbs, enzymes, aspirin, etc.

Medication	Dosage / Strength (example: mg)	What are the directions on the prescription / bottle?
Please use other side if necessary		

STATE LAW REQUIRES YOU LIST YOUR ALLERGIES AND TYPE OF REACTIONS

Please list your ALLERGIES: Medications, foods, or other items (i.e. latex)	**What type of REACTION do you have?**
Please use other side if necessary	

Chief Complaint (why are you seeing the doctor today?): _____

_____

_____

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Tri-City Gastroenterology Medical Group, Inc.

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MICHAEL SHIM, M.D.

SARA I. ANDOLINA, NP-C.

RECORD RELEASE FORM

NAME OF PATIENT: _____

DATE OF BIRTH: (Month) _____ /(Day) _____ /(Year) _____

I hereby authorize:

_____

_____

_____

To release to NORTH COUNTY GASTROENTEROLOGY MEDICAL GROUP, INC. my personal medical records, particularly: laboratory reports, x-ray reports, operative reports, consultations, history and physicals, and discharge summaries.

I understand that these records may contain information that is protected under federal regulations, including information related to the testing and treatment of the following: substance abuse or dependency, mental health or psychiatric conditions, and infectious diseases. These records will not be re-disclosed without my specific authorization. This medical information will be used for my medical care, evaluation and treatment.

This authorization will expire automatically in six months from the date executed.

SIGNATURE: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____

Patient Portal:

We have an interactive online portal designed specifically for you, our valued patient.

Start

- Take an active role in your healthcare.
- Create a username and password today.

Benefits

With the Portal you can…

- Request appointments.
- Check your results.
- Send a message to our office.
- Update your personal medical records.
- Log on 24/7 access from anywhere.

To Register…

1. You will receive an invitation email from our office with a link and unique ID that will take you through the registration process.
2. Click on the link in the invitation email to create a user ID and password.
3. Once registered, complete your medical, family and social history.
4. Click send to submit your information directly to our office.

How to…

Send a message to my Doctor's office?

- Click on the message tab.
- Click "new" and compose your message.
- Remember to hit send.

Receive messages through Patient Portal?

- You will receive a notification email when you have a message waiting in the portal.
- Log into your patient portal.
- Click on the message tab.
- Click on "new messages" to view your messages.

Update my personal information?

- Click on Health Summary, then click on update.
- Change the information you want.
- Click on "send" to submit changes.

Reset my password?

- Click on My Account/Change Password.
- Enter username, DOB and registered email address.

Questions…

- **Q:** Can I schedule my appointment online through Patient Portal? **A:** You may send a request to schedule your appointment and a staff member will contact you.
- **Q:** Does Patient Portal allow me to send a message directly to my physician's office? **A:** Yes, you may send a message directly to our office through Patient Portal. We will make sure your message reaches the correct staff member so that your question is answered.
- **Q:** What do I do if my account is locked due to too many failed log-in attempts? **A:** Click on "change password" tab and follow the instructions to create a new password.