DESERT RIDGE GASTROENTEROLOGY

Patient Demographic Information

(Please Print)

SS#_____-_____-_____ EMAIL_____

NAME_____
Last First Middle

ADDRESS_____

CITY_____STATE_____ZIP_____

BIRTHDATE_____/ _____/ _____ GENDER: (M / F) / MARITAL STATUS: S/M/W/D
Month Day Year

PRIMARY PHONE # ( )_____-_____OTHER # ( )_____-_____

EMPLOYER NAME_____PHONE#_____

EMPLOYER ADDRESS_____

SPOUSE NAME_____DOB____/____/_____

SPOUSE EMPLOYER_____PHONE#_____

EMPLOYER ADDRESS_____

PRIMARY CARE PHYSICIAN_____

PCP PHONE # ( )_____-_____

PRIMARY INSURANCE
Insurance_____
Policy #_____ Group #_____
Insured's Name_____Relation to Patient_____
Insured's DOB_____-_____-_____Insured's Employer_____
Insured's SSN_____-_____-_____

SECONDARY INSURANCE
Insurance_____
Policy #_____ Group #_____
Insured's Name_____Relation to Patient_____
Insured's DOB_____-_____-_____Insured's Employer_____
Insured's SSN _____-_____-_____

Please provide BOTH insurance cards during your check-in

May we leave messages regarding appointment(s) on your answering machine? Y___ N___

Signature_____Date_____-_____-_____

Patient Name: _____ DOB: _____/_____/_____

Chief Complaint: _____

_____

History of Present Illness: _____

_____

_____

_____

Drug Allergies: _____

_____

_____

_____

Current Medication: _____

_____

_____

_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertenson	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Crohn's or Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Stomach Ulcer	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Gall Bladder Dx	☐	☐	☐	☐	☐	☐

Habits

☐ Smoke: Packs Daily _____
How Long _____

☐ Exercise Routine: _____
_____

☐ Contact with blood/bodly fluids at work:
_____

☐ Coffee: Cups Daily _____
other caffeine _____

☐ Alcohol: Type _____
Amount _____
Frequency _____
How long _____

☐ Aspirin use:
Frequency _____
Amount _____
Dose _____

☐ NSAID use:
Drug _____
Amount _____
Dose _____

Hepatitis C risk factors

☐ Blood transfution prior to 1992 ☐ Drug use (1+ times) ☐ Contact with blood/bodily fluid ☐ Tattoos ☐ Body Piercing

Immunization (Year last received, if known)

Hepatitis _____ TB Skin Test _____

List any conditions you are being treated for: _____

_____

List any previous surgeries you have had: _____

Check (√) symptoms you currently have or have had in the past:

General
☐ Chills
☐ Depression
☐ Dizziness / Fainting
☐ Fatigue
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight
☐ Numbness
☐ Sweats

Muscle / Joint / Bone
Pain, weakness, numbness in:
☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

Genito-Urinary
☐ Blood in urine
☐ Frequent urination
☐ Lack of Bladder control
☐ Painful urination

Gastrointestinal
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Poor Appetite
☐ Diarrhea
☐ Difficulty Swallowing
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood

Cardiovascular
☐ Chest Pain
☐ High / Low blood pressure
☐ Irregular / Rapid heart beat
☐ Poor circulation
☐ Shortness of breath
☐ Swelling in ankles
☐ Varicose veins

Check (√) conditions you have had in the past:

☐ Anemia ☐ AIDS / HIV
☐ Alcoholism
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleedig Disorder
☐ Cancer
☐ Chemical Dependency
☐ COPD
☐ Colon Polyps
☐ Coronary Artery Dx
☐ Diabetes
☐ Elevated Liver Enzymes
☐ Epilepsy
☐ Esophageal Stricture
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ Herpes
☐ High Cholesterol
☐ Hypertentension
☐ Kidney Disorder
☐ Liver Disease
☐ Migraine Headaches
☐ Mitral Valve Prolapse
☐ Multiple Sclerosis
☐ Pacemaker
☐ Prostate Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid *Problems*
☐ Total Joint Replacement
☐ Tuberculosis
☐ Ulcers
☐ Valvular Heart Dx
☐ Venereal Disease

BRUCE S. SAND, D.O., FACOI
4045 E. BELL ROAD (SUITE 139)
PHOENIX, ARIZONA 85032

FINANCIAL POLICY

Welcome to Desert Ridge Gastroenterology & Liver Disease. We are committed to the delivery of the most comprehensive medical care for our patients. In addition, we would like to take this opportunity to inform you of our office insurance, payment, and billing policies. We bill insurance as a courtesy to our patients. We will accept payment from your insurance company, however, we require that you pay your insurance co-pay, co-insurance, or deductible responsibility prior to receiving your healthcare service(s). In addition, you will be responsible for payment prior to your appointment if our office is not in receipt of your required referral at the time of your visit.

If you fail to provide our office with your secondary and/or tertiary insurance cards during the check-in process and/or we are not a contracted provider, you agree that you will be responsible for all costs for services rendered by a non-participating provider. Payment is due in full within ten (10) business days of the date of your first billing statement. Failure to make payment in full within the foregoing timeframe will result in interest accruing on all unpaid amounts at the rate of 35% per annum, until paid. In the event that legal action is necessary in order to recover any amounts that remain unpaid, the prevailing party in such action will be entitled to an award of reasonable attorneys' fees and costs.

CO-PAYS

Your insurance co-pay is due during the check-in process prior to your rendered healthcare service. We do not bill for co-pays.

DEDUCTIBLE / CO-INSURANCE

If your insurance deductible / co-insurance is not met, full payment will be collected during the check-in process and prior to your rendered healthcare service. If your insurance deductible is met, your coinsurance amount will be collected 2 business days prior to your *scheduled* Colonoscopy / Endoscopy procedure(s).

PRIVATE PAY and OUT OF NETWORK

If you have no insurance (or elect not to use your insurance), full payment is due during the check-in process and prior to your rendered healthcare service. If we are out of network you will be responsible for charges not covered by your insurance plan and payment of such charges will be due in full during the check-in process and prior to your rendered healthcare service.

I have read and understand and agree to comply with the terms of this financial policy.

Signature_____ **Date**_____

DESERT RIDGE GASTROENTEROLOGY

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Review the following patient's rights information and provide your signature and date of consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing although such a revocation will not be retroactive.

By signing this HIPAA form, I understand that:

1) **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
2) **The practice reserves the right to change the privacy policy as allowed by law.**
3) **The patient has the right to restrict the use of information but the practice does not have to agree to those restrictions.**
4) **The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.**
5) **The practice may condition receipt of treatment upon execution of this consent.**

Please indicate to whom the physician / staff may discuss your healthcare in the event you are *incapacitated.* Additionally, if you have a medical representative acting on your behalf, you will need to provide our office with a copy of your designated Medical Power of Attorney document prior to receiving healthcare services.

_____

(Name) **(Patient Relationship)**

May we leave a phone message on your answering machine? **Yes_____ No_____**

May we leave a phone message confirming your appointment? **Yes_____ No_____**

_____

Patient Signature of Consent

_____

Date