ValleyCare Gastroenterology Medical Group, Inc.

Phillip A. Wolfe, M.D. Perrin D. Royea, PA-C
5575 West Las Positas Blvd., Suite 320, Pleasanton, CA. 94588

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State:_____ Zip:_____

Primary Phone #1: _____ #2 Home or Cell: _____ Email: _____

Social Security #: _____ Date Of Birth: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Were you referred to our office? YES / NO

Referring Doctor:_____Primary Care Physician:_____

Insurance Information

Primary Insurance Carrier: _____Subscriber: _____ Date of Birth: _____

Secondary Insurance Carrier: _____Subscriber: _____ Date of Birth: _____

Consent for Treatment/Insurance Authorization

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of ValleyCare Gastroenterology Medical Group, Inc. Transmittal by fax is authorized. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any balance not paid by my insurance (excluding contractual allowance). If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. Additionally, I understand that I am responsible for providing the referral from my primary care physician. In event that such a referral has not been provided to ValleyCare Gastroenterology Medical Group, I agree to pay for services at the time they are rendered.

Year 1. _____ _____
Patient Signature Date

Year 2. _____ _____
Patient Signature Date

Year 3. _____ _____
Patient Signature Date

I have read and understand the financial policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

_____ _____
Patient Signature Date

VALLEYCARE GASTROENTEROLOGY MEDICAL GROUP, INC
Phillip Wolfe, MD Perrin D. Royea, PA-C
5575 W Las Positas Blvd, Suite 320, Pleasanton, CA 94588
Phone 925-460-8167 Fax 925-460-0246

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Contact Preference

☐ Cell Ph# _____ ☐ Home Ph#_____ ☐ Patient Portal ☐ Patient declines to specify Other:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Penicillins ☐ Codeine Sulfate ☐ Sulfa (Sulfonamide Antibiotics) Other:_____ Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name Address Phone

Immunizations

- [ ] None
- [ ] Up to date
- [ ] unknown if up to date
- Other:
- Other:
- Other:

Diagnostic Studies/Tests

- [ ] None
- [ ] Colonoscopy When:
- [ ] Endoscopy When:
- [ ] Blood test/labs When:
- Other:
- Other:

Past or Present Medical Conditions

- [ ] None
- [ ] High blood pressure
- [ ] Heart Murmur
- [ ] Heart attack/angina
- [ ] Breast cancer
- [ ] Other Cancer
- [ ] Elevated cholesterol
- [ ] Enlarged Prostate (BPH)
- [ ] Hypothyroidism
- [ ] Diabetes
- [ ] Anxiety disorder
- [ ] Colon polyps
- [ ] Colon cancer
- [ ] Bleeding disorder
- [ ] Chronic Lung Disease
- [ ] Barrett's Esophagus
- [ ] Ulcer
- [ ] Ovarian cancer
- [ ] Blood clot/DVT/PE
- [ ] Emphysema
- [ ] Celiac disease
- [ ] Depression
- [ ] Prostate cancer
- [ ] Stroke
- [ ] Pacemaker/ Defibrillator
- [ ] Kidney Disease
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Pancreatitis
- [ ] Esohageal cancer
- [ ] Skin cancer
- [ ] Transfusions
- [ ] Anemia
- [ ] Liver cancer
- [ ] Asthma
- [ ] Gerd-Acid Reflux
- Other:

Previous Procedures

- [ ] None
- [ ] Appendectomy
- [ ] Cholecystectomy (gallbladder surgery)
- [ ] Hernia Repair
- [ ] Heart surgery
- [ ] Pacemaker/auto defibrillator
- [ ] Tonsillectomy
- [ ] Carpal tunnel surgery
- [ ] Joint surgery (knee, shoulder arthroscopy)
- [ ] Joint replacement
- [ ] Gastric bypass
- [ ] Hysterectomy
- [ ] C-section
- [ ] Plastic surgery
- [ ] Tubal ligation
- [ ] D and C
- [ ] Colon surgery/ resection
- [ ] Surgery

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union
- ⬭ Other

Alcohol

- ⬭ None
- ⬭ 1 drink/day
- ⬭ 2 drinks/day
- ⬭ 3-4 drinks weekly

Type:_____

Caffeine

- ⬭ None
- ⬭ 1 cup coffee/day
- ⬭ 2 cups coffee/day
- ⬭ soda

Intake:_____

Tobacco

Smoking Status

- ⬭ Current every day smoker
- ⬭ Current some day smoker
- ⬭ Former smoker
- ⬭ Never smoker
- ⬭ Smoker, current status unknown
- ⬭ Light tobacco smoker
- ⬭ Heavy tobacco smoker
- ⬭ Unknown if ever smoked

Drug Use

- ⬭ None

Type:_____

Exercise

- ⬭ None
- ⬭ 30 minutes daily
- ⬭ 20-30 minutes 3-4x/week
- ⬭ other

Type:_____

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon cancer ☐ Esophageal cancer ☐ Pancreatic cancer ☐ Stomach cancer

Health Status	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Age/Date of Birth	_____	_____	_____	_____	_____	_____	_____	_____
Deceased/At Age	○____	○____	○____	○____	○____	○____	○____	○____
Diagnoses								
GERD	○	○	○	○	○	○	○	○
Gastric Ulcers	○	○	○	○	○	○	○	○
Barrett's Esophagus	○	○	○	○	○	○	○	○
Irritable Bowel Syndrome	○	○	○	○	○	○	○	○
Gallbladder Problems	○	○	○	○	○	○	○	○
Diverticulosis	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Colon polyp	○	○	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Cirrhosis	○	○	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Cancer of Ovary, Uterus, Endometrium	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○
Bleeding Disorder	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Review Of Systems

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
body aches	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○
help: walking, dressing	○	○

Cardiovascular

None	Y	N
chest pain	○	○
difficulty breathing with exercise	○	○
irregular heart beat	○	○
palpitations	○	○
leg/ankle swelling	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
shortness of breath	○	○
excessive sputum	○	○
coughing up blood	○	○
wheezing	○	○

ENMT

None	Y	N
dizziness	○	○
ear pain	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
sensitivity to light	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
frequent urination at night	○	○
urinary incontinence	○	○
prostate problem	○	○
penile discharge	○	○
hysterectomy/menopause	○	○
irregular periods	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Hematologic/Lymphatic

None	Y	N
swollen glands/lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria/hives	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date

ValleyCare Gastroenterology Medical Group, Inc.-VCG

Consent to the Use and Disclosure of Health Information

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____hereby acknowledge that I have received or viewed a copy of the VCG Medical Group Notice of Privacy Practices. I understand the VCG has the right to change it Notice of Privacy Practices from time to time and that I may contact VCG at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian **Date**

Relationship to patient: _____ Patient's Date of Birth: _____

PROTECTED HEALTH INFORMATION (PHI) RELEASE AUTHORIZATION

Persons who are involved in your care (spouses, children, friends, etc. may inquire about your treatment, appointments, lab results, prescriptions, billing medical records, etc. Please let us know who we may share PHI with:

( ) Spouse: Name_____

( ) Child(ren): Name(s)_____

_____

( ) Other: Name and relationship _____

Please note: VCG will only release PHI to the individuals listed above.

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TELEPHONE CALLS/MESSAGES

Please call: ( ) First preference Phone # _____
( ) Second Preference Phone # _____

If unable to reach me:
( ) You may leave a detailed message
( ) Please leave a message asking me to return your call

I _____, acknowledge in signing this document that I am giving Valleycare Gastroenterology Medical Group authorization to release or discuss PHI either in writing or verbally to the persons specified above. This authorization is good indefinitely from the signature date below unless otherwise revoked by me in writing and a copy placed in my records at Valleycare Gastroenterology Medical Group, Inc.

Signature of Patient/Guardian _____Date _____