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: __________________________________ 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	O____	O____	O____	O____	O____	O____	O____	O____
Diagnoses								
GERD	O	O	O	O	O	O	O	O
Gastric Ulcers	O	O	O	O	O	O	O	O
Barrett's Esophagus	O	O	O	O	O	O	O	O
Irritable Bowel Syndrome	O	O	O	O	O	O	O	O
Gallbladder Problems	O	O	O	O	O	O	O	O
Diverticulosis	O	O	O	O	O	O	O	O
Ulcerative Colitis	O	O	O	O	O	O	O	O
Crohn's Disease	O	O	O	O	O	O	O	O
Colon polyp	O	O	O	O	O	O	O	O
Colon Cancer	O	O	O	O	O	O	O	O
Esophageal Cancer	O	O	O	O	O	O	O	O
Stomach Cancer	O	O	O	O	O	O	O	O
Pancreatic Cancer	O	O	O	O	O	O	O	O
Alcoholism	O	O	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O	O	O
Cirrhosis	O	O	O	O	O	O	O	O
Liver Cancer	O	O	O	O	O	O	O	O
Breast Cancer	O	O	O	O	O	O	O	O
Cancer of Ovary, Uterus, Endometrium	O	O	O	O	O	O	O	O
Celiac Disease	O	O	O	O	O	O	O	O
Bleeding Disorder	O	O	O	O	O	O	O	O
Other:	O	O	O	O	O	O	O	O

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 VCG Medical Group Notice of Privacy Practices. I understand that VCG has the right to change their 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____

( ) Children (over 18): ______________________ ______________________

( ) Other: Name and relationship ____________________________________

Please note: VCG will only release PHI to the individuals listed above by the phone, in person or in writing.

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Please note: how you will receive your results from our office.

You will receive your results from our office on our website patient portal. If you haven't signed up yet, please do. Use patient portal on website www.valleycaregastro.com

TELEPHONE CALLS/TEXT MESSAGES to you from our office:

Please call: ( ) First preference Phone # ____________________________________

If unable to reach me:

( ) You may leave a detailed message

( ) Please leave a message asking me to return your call

Ok to text me at #______________________ for appointment reminders, messages to change appointment, or please call our office. You may also text our office as a way to communicate with us.

I _______________________, acknowledge in signing this document that I am giving

Patient Name

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 __________

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining acknowledgements□ An emergency situation prevented us from obtaining acknowledgements□

Other (please specify): ____

(Revision 10/8/2020)