JONATHAN RIEGLER, MD Central Coast Gastroenterology
1255 Las Tablas Rd. Ste. 201, Templeton, CA 93465
Tel: 805-226-4106 Fax: 805-226-4108 Billing: 226-4490 Website: www.centralcoastgastro.com

Please print

PATIENT:

Legal Name: _____ Nickname_____
M___F___Date of Birth_____Social Security #_____Marital Status S___M___D___W___
Mailing Address _____
City_____State_____Zip_____-_____
Home Phone (_____)_____cell phone (_____)_____
Work phone (____)_____ Preferred Message phone: Home …Cell …Work… (circle)

Email:_____

Yes No (circle one) I would like access to my medical records on line. If yes, you will receive an email with your user name & password from Central Coast Gastro.

Race/Ethnicity: White___ Hispanic/Latino___ American Indian/Alaska Native___ Asian___
Black/African American___ Native Hawaiian/Pacific Islander ___

Primary Language _____

Primary Doctor_____**Referred by:**_____
Pharmacy_____**PharmacyLocation**_____
Employer_____Occupation_____
Emp. Phone: (_____)_____
Contact Person not living with you_____Relationship_____
Address_____
City_____State_____Zip_____Phone(____)_____

SPOUSE or Parent if Guarantor

Name: _____ Date of Birth_____
Phone if different: (____)_____Cell: (____)_____
Address if different_____

Primary Ins._____**ID#**_____**Group #**_____

Secondary Ins._____**ID#**_____**Group#**_____

PLEASE BRING YOUR INSURANCE CARDS AND PICTURE ID/DRIVER'S LICENSE WITH YOU.
Your co-pay is due at the time of your appointment. Please come prepared to pay.
IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS.
If you have questions, please call our billing department at 805-226-4490.

I authorize Jonathan Riegler, MD, to bill my insurance and to release my medical records or other information to my insurance carriers, other physicians or medical facilities. I understand I am financially responsible for all charges whether or not covered by my insurance.

Cancellation Policy: We request a 48-hour cancellation notice. A fee of $50 for office visits and $100 for procedures will be charged if a patient fails to show for a scheduled appointment. This charge would not be billed to your insurance company.

_____ _____
Signature **Date**

Central Coast Gastroenterology Medical Group

Name: _____
DOB: _____ Today's Date: _____
Age: _____

Steven W. Carlson, M.D.
Gary L. Cushing, M.D.
Jeffrey B. Mundorf, M.D
Vance D. Rodgers, M.D.
Daniel C. Zovich, M.D.
Paul D. Wetzel, M.D
Jonathan L. Riegler, M.D

What brings you into the office today?

Preventative care YES/NO	Date of Onset

CURRENT MEDICATIONS: prescriptions and over the counter and supplements

Name of Medicine	Strength of Each Dose	How Often Taken	When Began Taking

Are you allergic to any medications?

None_____ or list medications	reaction & severity	medication	reaction & severity
	mild/moderate/severe		mild/moderate/severe
	mild/moderate/severe		mild/moderate/severe

FAMILY HEALTH

*__Do you have any blood relative with a history of colon cancer?__ YES/NO if yes, who:_____ age:____

Relation	Age	Still alive?	State of Health or Cause of Death	History of colon cancer or colon polyps?
Mother		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
Father		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
Brothers and Sisters		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
Grandparents		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___
		( ) yes ( ) no		( ) yes( ) no if yes, age at diagnosis___

SURGICAL HISTORY

Have you had any problems with anesthesia in the past? Yes_____ No _____

Operation	Hospital and City	Date

* * Please fill out both sides of this form* *

Reviewed by _____

*Name*_____ *Today's Date:*_____

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
angina			glaucoma			migraine headaches		
anxiety			heart attack			murmur		
arthritis			Heart stent			palpitations		
asthma			hepatitis			Parkinson's disease		
cataract extraction			high blood pressure			peptic ulcer disease		
Have you ever had colon cancer?			high cholesterol			prostate cancer		
colon polyps			insomnia			prostate enlargement		
COPD/chronic bronchitis			jaundice			seizures		
depression			kidney disease or kidney stones			stroke		
diabetes			Lupus			thyroid disease		
emphysema			Melanoma			TIA		
endometriosis			menopause			trouble breathing		
fibromyalgia			Have you had a flu vaccine during the most recent flu season (Sept to feb)?			Do you require antibiotic prophylaxis before medical procedures?		
Do you have sleep apnea?			Do you use pressurized ventilation or mouthpiece while sleeping?			Would you accept blood products if needed?		
gallbladder disease/gallstones								
Are you currently pregnant?			**Have you ever had the Pneumonia Vaccine?**			Hepatitis A, B, C, D or E? (circle one)		
Do you smoke? (circle one) Daily/ Some days/ Former Smoker/Never Smoked			Do you drink alcohol? Yes or No If so, how much do you drink? _____/day/wk/month			Do you use marijuana or other street drugs?		

Do you have any of the following symptoms?

	yes	no		yes	no		yes	no
nausea or vomiting			chest pain			hearing loss		
diarrhea			palpitations			oral problems		
constipation			numbness, weakness, or tingling			cough or wheezing		
blood in your stools or rectal bleeding			painful urination or blood in the urine			intolerance to heat or cold		
heartburn			back pain			weight gain		
fever or chills			joint pain			weight loss		
easy fatigability			rash or itching			hair loss		
headaches			visual changes			easy bleeding or bruising		

SCREENING EXAMS

Please list the results of the following tests:	*Date done*	*Where were these performed?*
BLOOD TESTS		
HEMOCCULT OF STOOLS (Tests for Blood in Stool)		
SIGMOIDOSCOPY		
COLONOSCOPY		

IMAGING EXAMS

*Please list the results of the **most recent** following tests:*	Date performed	Where were these performed?
X-RAYS(abdominal xray or UGI or Barium enema)		
ULTRASOUND OF ABDOMEN		
CAT SCAN OF ABDOMEN		

Reviewed by _____