Paul D. Wetzel, M.D.
(805) 549-7843

Please be prepared to pay co-pay and/ or deductible at time of service.

PATIENT:

Full Legal Name ______________________________ Nickname ________________
Date of Birth: ________________ Marital Status: S__M__D__W__ Sex: M___F___
Race: (circle one) White/African Am/Asian/Hispanic/Other
Address_____________________________City_____________State___Zip_______
Home Ph(   ) _____________Work Ph(   )_____________Cell(   ) __________________
Primary Doctor _________________________ Referred by ______________________
Employer ________________________________ Occupation ________________
Employer Address ____
Contact Person not living with you ____________________Phone (   ) ______________
Pharmacy_________________________ **Email** _____________________________

SPOUSE

Name ___________________________ Date of Birth ______________________
Employer ________________________ Phone (   ) ______________________

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COMPANY BENEFITS

Initial **Please bring your picture id and insurance cards with you.**

______**FINANCIAL POLICY:** We will bill your insurance company, however, you, not your insurance company, are ultimately responsible for paying our bill. It is your responsibility to notify our office of your insurance carrier and plan.

______**AGREEMENT:** I have read the financial policy and understand my financial obligations. I also understand that I am financially responsible for all charges whether or not covered by my insurance.

______**MEDICARE PATIENTS:** This office accepts Medicare assignment. This means that Medicare pays 80% of our charges and that you pay the remaining 20%. If you have a supplement or secondary insurance carrier they will be billed as a courtesy for you.

______**HIPAA**: I hereby acknowledge that I received a copy of Dr Wetzel's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

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

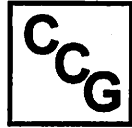
Primary Ins. __________________**ID#**________________**Group#**______________
Primary Insurance Phone #________________________________

Secondary Ins. __________________**ID#**________________ **Group#**_____________
Secondary Insurance Phone #______________________________

______ I hereby authorize Paul D. Wetzel, M.D. to provide medical treatment for myself.

______________________________________ ____________________
Signature Date

Central Coast Gastroenterology Medical Group



Name: ______________________________
DOB: ____________ Today's Date: ______________
Age: ________

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 colon cancer? YES/NO if yes, who:________ diagnosed at what age____

Any blood relative with: Ovarian cancer______ Uterine (endometrial) cancer______

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 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 ______________