PATIENT INFORMATION

CENTRAL COAST GASTROENTEROLOGY MEDICAL GROUP
JEFFREY B. MUNDORF, MD INC.
MICHELLE C. CORDOVA, PA-C

PATIENT:

Full Legal Name:_____ ☐ Male ☐ Female

Mailing Address:_____ Date of Birth_____ Age_____

City_____ Zip_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Phone # (_____)_____ Cell Phone #(_____)_____

Social Security #_____ Employer_____

Primary Care Physician_____ Address_____

Insurance Carrier and Member Identification #: _____City _____

_____ Phone# (_____) _____

Emergency Contact Person & Phone #:_____Occupation:_____

_____

PARENT/SPOUSE:

Name _____ Date of Birth_____

Employer_____ Phone # (_____) _____

Address_____ Social Security #_____

Local Pharmacy:_____**Phone:**_____

Language/Race/Ethnicity Demographic Questions

In order to satisfy the new government requirement for Meaningful Use of Electronic Health Records, we need to ask you about you ethnic origin, race and language preference. Please understand you are under no obligation to answer and you may decline to do so.

Language:
- ☐ English
- ☐ Arabic
- ☐ Cantonese
- ☐ Hebrew
- ☐ Japanese
- ☐ Korean
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish

Race:
- ☐ White
- ☐ American Indian or Alaska native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Declined to answer

Ethnic Origin:
- ☐ Hispanic / Latino
- ☐ Not Hispanic/ Latino
- ☐ Declined to answer

****It is your responsibility to know benefits provided by your insurance company****

FINANCIAL POLICY:

- **Medicare:** This office accepts Medicare assignment. This means Medicare pays 80% of the allowable charges and you pay the remaining 20%. In addition, you are responsible for paying the annual Medicare deductible. Supplemental or secondary plans may cover the 20% Medicare allows but does not pay. This office will bill most of these insurance plans. However, you are responsible for any balance of the 20% your secondary does not cover. If the possibility exists that Medicare will not cover anticipated charges, you will be notified in advance and will be asked to sign an Advance Beneficiary Notice (ABN).
- **PPO, HMO (Contracted Plans):** Know your coverage. **All** appointments will be scheduled **after** receiving any required authorization from your insurance company. **Co-pay's are due at the time of service.** We will submit your claim to your insurance carrier. You will continue to receive statements that reflect any insurance payments received by us and any co-payments or balance that you owe.
- **Other Private Insurance (Non-contracted Plans):** If you are covered by an insurance company that our office does not contract with, payment for an office visit is expected at the time of the visit. Payment for hospital services is expected when you receive our statement. While every effort will be made to assist you with the insurance billing, **you**, not your insurance company, are responsible for paying our bill.

AGREEMENT: I have read the financial policy and understand my financial obligations. I hereby authorize Central Coast Gastroenterology Medical Group to release my medical records or other information to the insurance carrier, to the physician from whom I was referred, or to any physician or facility to which CCGMG may refer me. I also understand that I am financially responsible for all charges whether or not covered by insurance.

_____ _____

Signature Date

Central Coast Gastroenterology Medical Group

Phillip M. Colbert, M.D.
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

Name: _____

DOB:_____ Today's Date:_____

What brings you into the office today?

Problem	Date of Onset

☐ No Current Medications

CURRENT MEDICATIONS

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

☐ No known Drug Allergies

Are you Allergic to any Medications?

Medication	Reaction

Medication	Reaction

FAMILY HEALTH

Please complete every line of family history, to the best of your knowledge.

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___

Do you have any Blood Relatives with a History of Colon Cancer? ☐ Yes ☐ No If yes, whom_____

SURGICAL HISTORY

Operation	Hospital and City	Date

Name_____DOB:_____Today's Date:_____

MEDICAL HISTORY

Please Check Yes or No for Every Question.

	Yes	No
angina		
anxiety		
arthritis		
asthma		
cataract extraction		
Have you ever had colon cancer?		
colon polyps		
COPD/chronic bronchitis		
depression		
diabetes		
emphysema		
endometriosis		
fibromyalgia		
gallbladder disease/gallstones		
Are you currently pregnant?		
Do you smoke? (circle one) Daily/ Some days/ Former Smoker/Never Smoked		

	Yes	No
glaucoma		
heart attack		
hepatitis		
high blood pressure		
high cholesterol		
insomnia		
jaundice		
kidney disease or kidney stones		
lupus		
melanoma		
menopause		
migraine headaches		
Do you require antibiotic prophylaxis before medical procedures?		
Have you ever had the Pneumonia Vaccine?		
Do you drink alcohol? ☐ Yes ☐ No If so, how much do you drink? _____		

	Yes	No
murmur		
palpitations		
parkinson's disease		
peptic ulcer disease		
prostate cancer		
prostate enlargement		
seizures		
sleep apnea		
stroke		
thyroid disease		
TIA		
trouble breathing		
Would you accept blood products if needed?		
Hepatitis A, B, C, D or E? (circle one)		

Do you have any of the following symptoms?

Please Check Yes or No, on Every Question.

	Yes	No
nausea or vomiting		
diarrhea		
constipation		
blood in your stools or rectal bleeding		
heartburn		
fever or chills		
easy fatigability		
headaches		

	Yes	No
chest pain		
palpitations		
numbness, weakness, or tingling		
painful urination or blood in the urine		
back pain		
joint pain		
rash or itching		
visual changes		

	Yes	No
hearing loss		
oral problems		
cough or wheezing		
intolerance to heat or cold		
weight gain		
weight loss		
hair loss		
easy bleeding or bruising		

SCREENING EXAMS

Please answer each of the following questions:	Date Done	Where were these performed?
BLOOD TESTS		
HEMOCCULT OF STOOLS (Tests for Blood in Stool)		
SIGMOIDOSCOPY (list only if in the last 5 years)		
COLONOSCOPY (list only if in the last 10 years)		

X-RAY EXAMS

*Please list the **Most Recent** of the following tests and where they were performed:*		Date Performed
UPPER GI SERIES (Stomach X-Rays)		
LOWER GI SERIES (Barium Enema)		
ULTRASOUND OF ABDOMEN		
CAT SCAN OF ABDOMEN		