Desert Valley Gastroenterology

a division of

arizona gastrointestinal associates

Ryan Fauble, MD • Steven Kaiser, MD, FACP, FACG •
Priti Sud, MD• Anitha Yadav, MD•

4540 E Baseline Rd Suite 115 Mesa, AZ 85206 Tel (480) 306-6405 Fax (480) 306-6409

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Printed Name: _____ **Date of Birth:** _____

I hereby authorize Desert Valley Gastroenterology to:

___ **Request and Obtain** my medical records for my continuing medical care.

___ **Release** medical records FROM Desert Valley Gastroenterology for the purpose of:

__**Continuing Medical Care** __Other_____

I authorize the use and disclosure of my entire medical record in the possession of Desert Valley Gastroenterology. Any further disclosure of medical record information by the recipient(s) is not authorized without specific written consent of the person to whom it pertains. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. Insurance company or Health Care Professional, it may no longer be protected by the federal and state privacy regulations. For the purpose hereof, "Entire Medical Record" shall include ALL confidential and HIV-related information (as defined in A.R.S. section 36-661), confidential Alcohol or drug Abuse related information (as defined in 42 CF section 2.1 ET SEQ), and confidential Mental Health Diagnosis/Treatment information. This authorization may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I am aware that this authorization shall become effective immediately and shall remain in effect for one year from the day of signature. A copy of this signed authorization is valid as an original.

X Signature of Patient or *Legal Representative:* _____ **Date:** _____

If signed by representative:

__Print name of signing representative:_____

__Give relationship to patient:_____

__ Patient was unable to sign because_____

__ Patient refused to sign.

Patient Information:

Name_____

Social Security #_____

Date of Birth_____

Address_____

Apt#_____

City_____

State_____ Zip_____

Gender _____

Language ⬭English ⬭Spanish ⬭ Other

Race

⬭White/Caucasian
⬭Black/ African American
⬭Asian
⬭American Indian or Alaska Native
⬭Native Hawaiian/ other Pacific Islander
⬭Other
⬭Unknown
⬭Patient Declines to provide information

Ethnicity

⬭ Not Hispanic or Latino
⬭ Hispanic or Latino
⬭ Patient Declines to provide

Employer

Name_____

⬭Full Time ⬭Part Time ⬭Retired
⬭Unemployed

Phone #_____

Alt # _____

E Mail_____

Contact preference (please circle)

Phone call Email

Ok to leave automated message

Yes___ No___

Primary Physician:_____

PCP Phone: _____

Referring Physician: _____

Referring Phone:_____

Emergency Contact:

Name_____

Phone_____

Relationship_____

Authorized Individual: Please authorize any individuals, not including your physicians (example: Spouse, Parent, Child), who you would like us to be allowed to release information to, or who would ever call on your behalf by listing their information below. We will not speak with anyone who is not authorized.

⬭ **Same as Emergency Contact**

Name:_____

Phone:_____

Name: _____

Phone:_____

BILLING INFORMATION

Name of Responsible Party/Guarantor (if different from patient): _____

Date of Birth _____ Relationship to Patient: _____ Phone _____

Mailing Address: _____ (unit/apt) _____

City _____ State _____ Zip Code _____

If you provided a copy of your insurance card for our records, you may check here: ☐ Copy on file
If you were unable to present a copy of your insurance card for our records, please provide complete insurance information.

Prim Insurance Company: _____ Name of Policy Owner: _____

Member ID: _____ Group Number: _____

Sec Insurance Company: _____ Name of Policy Owner: _____

Member ID: _____ Group Number: _____

By signing, I hereby acknowledge that this Patient Information is correct, and I understand that I must immediately provide any changes to the above information in writing.

x Signature of Patient or *Legal Representative:* _____ Date: _____

Office staff only:
Medicare Yes_____ No_____
If yes, ACO notification provided
Yes_____ No_____
If declined, Signature obtained
Yes_____ No_____

arizona
gastrointestinal
associates

4540 E Baseline Rd Ste 115 Mesa, Az 85206• O (480) 306-6405 • F (480) 306-6409

FINANCIAL POLICY

Thank you for choosing Arizona Gastrointestinal Associates as your health care provider. The following is an explanation of our financial policy, which we require you to read and sign prior to receiving any services.

- Full payment of copays and deductibles are due at time of service. We accept cash, checks and credit cards. There will be a $50.00 service fee charge on returned checks.
- Missed appointments without adequate notice will be charged a $50.00 fee for office visits (24 hour notice) and $150.00 for procedures (48 hour notice).
- We will file medical claims to your health insurance carrier, on your behalf, for services rendered by this office. We will require all information for filing be received at time of service.
- Be advised that verification of eligibility and benefit information obtained from your carrier is **not** a guarantee of payment. Should our claim, in full or partially, be denied by your carrier, you are responsible for **all** charges not covered, and payment in full is expected promptly.
- You, as the insured member, are responsible for knowledge and understanding of your plan's benefit requirements. Many carriers require referrals for certain services. You are responsible for verifying a referral is on file for you visit.
- Your medical records may be copied upon request, with written authorization. Please allow 2 weeks to copy your records. The Arizona Legislature (A.R.S. 12-2295) states that a reasonable fee for copying your records can be charged. **Arizona Gastrointestinal Associates charges $0.50(fifty cents) per page.** This fee will be due prior to release of records. **We will also charge you the actual cost for postage if you have the copies mailed to you.** No postage charge will apply if you pick up your records. There will be no charge for records sent to another physician or healthcare provider involved with your continuity of care.

I certify that I have read and fully understand the financial policies of Arizona Gastrointestinal Associates.

Patient Signature: _____ Date: _____

Desert Valley Gastroenterology

Patient Information

First Name: _____ Last Name: _____ DOB: _____

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Latex
- ☐ Penicillins
- ☐ Demerol
- ☐ Fentanyl
- ☐ Versed
- ☐ Iodine
- ☐ Propofol
- ☐ Sulfa
- ☐ Eggs
- ☐ Other: _____

Past or Present Medical Conditions

☐ Patient has no known medical conditions

NEUROLOGY
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Dementia
- ☐ Parkinson's

ENDOCRINE
- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Osteoperosis
- ☐ Elevated Cholesterol

CARDIAC
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure

LUNGS
- ☐ Asthma
- ☐ COPD
- ☐ Valley Fever
- ☐ Sleep Apnea

URINARY
- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Kidney Stones
- ☐ Kidney Cancer

RHEUMATOLOGY
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Rheumatoid Arthritis

PSYCHIATRIC
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia

CIRCULATION
- ☐ Deep Vein Thrombosis
- ☐ Carotid Artery Disease
- ☐ Pulmonary Embolus
- ☐ Peripheral Vascular Disease

BLOOD
- ☐ Anemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding Disorder

GASTROINTESTINAL
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Pancreatitis
- ☐ Barrett's Esophagus
- ☐ GERD
- ☐ Cirrhosis
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Colon Cancer
- ☐ H. pylori
- ☐ Lactose Intolerance
- ☐ Crohn's Disease
- ☐ Celiac Sprue

☐ **CANCER** Type: _____

CONDITIONS NOT LISTED: _____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy ☐ Upper Endoscopy ☐ ERCP ☐ EUS

When: _____ When: _____ When: _____ When: _____

☐ Ultrasound ☐ CT Scan ☐ MRI ☐ Liver biopsy ☐ Recent labs

When: _____ When: _____ When: _____ When: _____ When: _____

Previous Procedures & Surgeries

☐ None

☐ Cataract surgery ☐ Tonsillectomy ☐ Thyroid surgery ☐ Heart valve ☐ Pacemaker

☐ Defibrillator ☐ Appendectomy ☐ Gallbladder removal ☐ Carotid artery ☐ Abdominal aneurysm

☐ C-section ☐ Hysterectomy ☐ Tubal ligation ☐ Breast surgery ☐ Prostate surgery

☐ Joint surgery ☐ Bowel surgery ☐ Hemorrhoids ☐ Coronary bypass ☐ Coronary artery stent

☐ Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union ☐ Other: _____

Alcohol

	Quantity	Number	Frequency
☐ None			
☐ Beer			
☐ Wine			
☐ Hard Liquor			

Tobacco/Smoking Status

☐ Current, Every Day Smoker ☐ Current, Some Day Smoker ☐ Former Smoker

☐ Smoker, Status Unknown ☐ Unknown if ever smoked ☐ Never Smoked

Drug Use

	Quantity	Number	Frequency
☐ None			
☐ IV Drugs			
☐ Other:			

Caffeine

☐ None ☐ Coffee ☐ Soda ☐ Energy Drinks ☐ Tea

Family Medical History

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ No knowledge of family history

☐ No family history of: ☐ Colon Cancer ☐ Polyps

Current Medications

☐ Patient has no known medications

Name	Dose	How Taken?

Consent to Import Medication History

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

◯ Yes ◯ No

If all of the symptoms below are "no" you can simply skip over it

Review of Systems

Constitutional

- ⬭ Fatigue
- ⬭ Fever
- ⬭ Chills
- ⬭ Loss of weight (unintentional)

Ear Nose Mouth & Throat (ENMT)

- ⬭ Dizziness
- ⬭ Hoarseness of voice

Cardiovascular

- ⬭ Chest pain
- ⬭ Shortness of breath w/ exercise
- ⬭ Palpitations
- ⬭ Ankle swelling

Respiratory

- ⬭ Asthma
- ⬭ Cough
- ⬭ Shortness of breath w/ exercise
- ⬭ Wheezing

Gastrointestinal

- ⬭ Abdominal pain
- ⬭ Stomach Cramps
- ⬭ Heartburn
- ⬭ Gas
- ⬭ Nausea
- ⬭ Vomiting
- ⬭ Change in Bowel Habits
- ⬭ Diarrhea
- ⬭ Constipation
- ⬭ Rectal bleeding
- ⬭ Jaundice

Genitourinary

- ⬭ Urinary burning
- ⬭ Frequent urination
- ⬭ Urinary Incontinence
- ⬭ Urinary hesitancy

Hematologic/Lymphatic

- ⬭ Easy Bruising
- ⬭ Prolonged bleeding

Integumetary (Skin)

- ⬭ Allergies
- ⬭ Itching
- ⬭ Jaundice
- ⬭ Rash

Musculoskeletal

- ⬭ Arthritis
- ⬭ Back Pain
- ⬭ Stiffness

Neurological

- ⬭ Dizziness
- ⬭ Numbness
- ⬭ Seizures

Psychiatric

- ⬭ Anxiety
- ⬭ Panic Attacks
- ⬭ Depression
- ⬭ Difficulty Sleeping

Have you had recent labs/ imaging? If so what facility? _____

_____

Have you been hospitalized recently? If so what hospital?_____

_____