Susanna Chan, M.D.
Jerome Cohen, M.D., FACP
Norman Panitch, M.D., FACP
Edward Piken, M.D.

South Bay
Gastroenterology
Medical Group
Affiliated with the Endoscopy Center of the South Bay

Gloria Sze, M.D.
Tonny M. Lee, M.D.
Oren Zaidel, M.D.
Wendy Ard, PA-C

Dear _____,

You have an appointment with Dr._____

On _____ at _____AM / PM

We ask that you arrive at least 15 minutes early to Suite 260 with the enclosed forms **COMPLETED** and please bring your insurance card(s) and Identification card. **PLEASE DO NOT MAIL YOUR FORMS TO US ! ! !**

If you have any additional medical information from a referring physician, such as: medical records, lab work, x-rays, etc. please bring them with you.

If your insurance coverage requires prior authorization, **it is imperative that you bring your authorization referral with you to avoid rescheduling.**

We appreciate your cooperation. Should you have any questions, please do not hesitate to call our office at (310) 539-2055.

Please notify office if change is necessary. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Thank You,

Scheduling Dept.

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
The Endoscopy Center of the South Bay

Please check which provider you are seeing:

Susan M. Chan, M.D.
Jerome Cohen, M.D.
Tonny M. Lee, M.D.
Edward Piken, M.D.
Gloria Sze, M.D.
Oren Zaidel, M.D.
Wendy Ard, PA-C

PRACTICE LIMITED TO GASTROENTEROLOGY
23600 Telo Avenue, Suite 260
Torrance, California 90505
Telephone # (310) 539-2055
Southbaygastro.com

Endoscopy Center of the South Bay
23560 Madison Street, Suite 109
Torrance, California 90505
Telephone # (310) 325-6331

PATIENT INFORMATION

PATIENT NAME: _____ AGE _____ DATE OF BIRTH:_____

ADDRESS: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE:_____ WORK: _____ CELL: _____

HOW DO YOU PREFER TO BE CONTACTED? HOME WORK CELL OR OTHER: _____

MARITAL STATUS: _____ GENDER:_____

EMAIL ADDRESS:_____

DO YOU RESIDE IN A SKILLED NURSING FACILITY: _____

FAMILY PHYSICIAN (REFERRING PHYSICIAN): _____ PHONE#_____

PHARMACY NAME: _____ADDRESS: _____ PHONE: _____

RACE: WHITE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER AMERICAN INDIAN-ALASKAN NATIVE OTHER

ETHNICITY: HISPANIC OR LATINO NON-HISPANIC OR LATINO Preferred Language: ENGLISH OTHER:_____

PRIMARY INSURANCE

COMPANY: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP: _____

MEMBER # _____GROUP # _____

NAME OF INSURED: _____INSURED SSN:_____

INSURED DATE OF BIRTH: _____RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE INFORMATION

COMPANY: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP: _____

MEMBER # _____GROUP # _____

NAME OF INSURED: _____INSURED SSN:_____

INSURED DATE OF BIRTH: _____RELATIONSHIP TO PATIENT:_____

EMPLOYMENT INFORMATION

EMPLOYER: _____TELEPHONE: _____

ADDRESS: _____CITY, STATE, ZIP_____

RELATION TO PATIENT:_____

EMERGENCY NOTIFICATION

CONTACT:_____TELEPHONE: _____

RELATIONSHIP: _____

_____ _____

SIGNATURE OF PATIENT DATE

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
AND
The Endoscopy Center of the South Bay - Patient History Form *pg 1 of 2*

[PATIENT LABEL]

Patient's Name: _____

Date of Birth: _____

Occupation: _____

Marital Status: Married Divorced Single Widowed

Age _____ Weight _____ lbs Height_____ft _____inches

Reason for Visit: Rectal bleeding Anemia
Family History Re-Check Change in Bowel Habits
Abdominal Pain Other: _____
_____
_____

History: **Relation:**

- ○ Cancer (type) _____
- ○ Polyps (colon/stomach) _____
- ○ Ulcers _____
- ○ Liver Disease _____
- ○ Pancreatitis _____

Family History	**If Living**		**If Deceased**	
	Age	Health	Age	Cause
Father				
Mother				
Brother/Sister				
Other Blood Relatives				
Son/Daughter				

Do you smoke? __ Yes No
packages per day _____
of years smoked _____

Do you use alcohol? __ Yes __ No
drinks per day _____

Illnesses/Surgeries: PLEASE PROVIDE DATES
(If none, please indicate with N/A)
1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a Colonoscopy or an Upper Endoscopy before? Yes No When? _____
Results: _____

Medications: List all Medications, Dosage & Frequency. (This should include: All Prescription, Herbal and over the counter Medications) If not applicable, please indicate with N/A. If necessary please use the back of this form or attach a list.

DRUG NAME DOSAGE HOW OFTEN
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Herbals, Vitamins, Supplements & Non - Prescriptive Drugs:
1. _____
2. _____
3. _____

Allergies: Include Medication, Foods and Latex. Please note reactions. ***(If not applicable indicate with N/A)***
No Known Allergies
LATEX ALLERGY? YES No Reaction; _____
_____

DRUG ALLERGIES **TYPE of REACTION**
1. _____
2. _____
3. _____
4. _____
5. _____

FOOD ALLERGIES **TYPE of REACTION**
1. _____
2. _____
3. _____

[PATIENT LABEL]

Patient Name: _____

Cardiovascular

Heart Murmur	Yes	No
Heart Valve Replacement	Yes	No
Chest Pain	Yes	No
Heart Attacks	Yes	No
If yes, please provide dates: _____		
Heart Stents	Yes	No
If yes please provide dates:_____		
_____		
High Blood Pressure	Yes	No
Defibrillator / Pacemaker	Yes	No
AICD/ *CRMD	Yes	No
Cardiac Rhythm Management Device		
High Cholesterol	Yes	No
Heart Surgery	Yes	No
Swelling of Ankles	Yes	No
Cardiomyopathy or Congestive Heart Failure	Yes	No

Constitutional

Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No

Endocrine

Heat or Cold Intolerance	Yes	No
Excessive Thirst or Urination	Yes	No
Diabetes TYPE 1 or TYPE 2	Yes	No
Thyroid Trouble	Yes	No

Eyes/Skin/ENT

Blurred and double vision	Yes	No
Glaucoma	Yes	No
Rash / Itching	Yes	No
Jaundice	Yes	No
Hearing Loss / Ringing In Ears	Yes	No
Mouth Sores	Yes	No
Nosebleeds	Yes	No

Gastrointestinal

Poor Appetite	Yes	No
Difficulty in Swallowing	Yes	No
Heartburn and Indigestion	Yes	No
Nausea or Vomiting	Yes	No
Bloating / Belching	Yes	No
Regurgitation	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Abdominal Pain	Yes	No
Recent Change In Bowel Habits	Yes	No
Rectal Bleeding	Yes	No
Black, Tarry Stools	Yes	No
Gallbladder Disease	Yes	No
Liver Trouble	Yes	No
Hemorrhoids	Yes	No
Hiatal Hernia	Yes	No

Musculoskeletal

Joint Pain or Swelling	Yes	No
Back Pain / Muscle Pain	Yes	No

Genitourinary

Burning w/Urination	Yes	No
Blood in Urine	Yes	No
Kidney Trouble	Yes	No

Hematological

Bleeding/Bruising Tendency	Yes	No
Anemia	Yes	No
Blood Transfusion	Yes	No

Respiratory

Chronic Cough	Yes	No
Spitting up Blood	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No
Do you use Oxygen?	Yes	No
COPD	Yes	No
Obstructive Sleep Apnea	Yes	No
Do you use a CPAP Machine	Yes	No

Infectious Disease

Hepatitis	Yes	No
Type: _____		
AIDS	Yes	No
HIV	Yes	No
Do you currently have any condition that has been deemed		
Infectious / communicable	Yes	No
If yes explain: _____		
Other: _____		

Psychiatric

Memory Loss/Confusion	Yes	No
Depression	Yes	No
Panic Attacks/Anxiety Disorder	Yes	No

Neurological

Dementia	Yes	No
Alzheimer's	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Strokes	Yes	No
Difficulty laying on Left Side	Yes	No
Numbness	Yes	No
If yes, where? _____		
Weakness (Left or Right)	Yes	No

Are you Pregnant? Yes No

Is there anything else we should know regarding your medical history? *(Please use an additional sheet if necessary)*

_____

Who is your referring Doctor?: _____

Phone No: _____ **Fax No.:** _____

Who is your Primary Doctor?:__

Phone No: _____ **Fax No.:** _____

Address: _____

_____

Do you have a Cardiologist? No Yes Please provide:

Name: _____

Phone #:_____

Patient Signature: _____

Date:_____

Physician's Signature: _____

Date:_____

C.R.N.A's Signature: _____

Date:_____

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
AND
The Endoscopy Center of the South Bay

OFFICE POLICY FOR
INSURANCE BILLING

South Bay Gastroenterology Medical Group & Endoscopy Center of the South Bay have enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations; we must rely on you, the patient, to inform us EACH time of services exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as **lab work, screening / preventative care, hospitalization, and/or out-patient procedures** that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

• • • • • • • •

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

The Endoscopy Center of the South Bay
And
South Bay Gastroenterology Medical Group

Authorization to Leave Message:

I hereby authorize **SBGMG/ECSB** to leave a message regarding pending appointments or tests at the following: (please circle)

Home : Yes / No Phone Number: _____

Cell Phone : Yes / No Phone Number: _____

Work : Yes / No Phone Number: _____

You may contact me via my Email : Yes / No Email Address: _____

You may leave a message with any of the individuals listed below:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Print Patient Name: _____

Patient, Parent or Guardian _____ **Date:** _____
(Signature)

H2.6c NOTICE OF PRIVACY PRACTICES

Endoscopy Center of the South Bay - South Bay Gastroenterology Medical Group- This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your care and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree on such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact: Center Director and /or Office Manager.

Effective Date: (date form implemented)

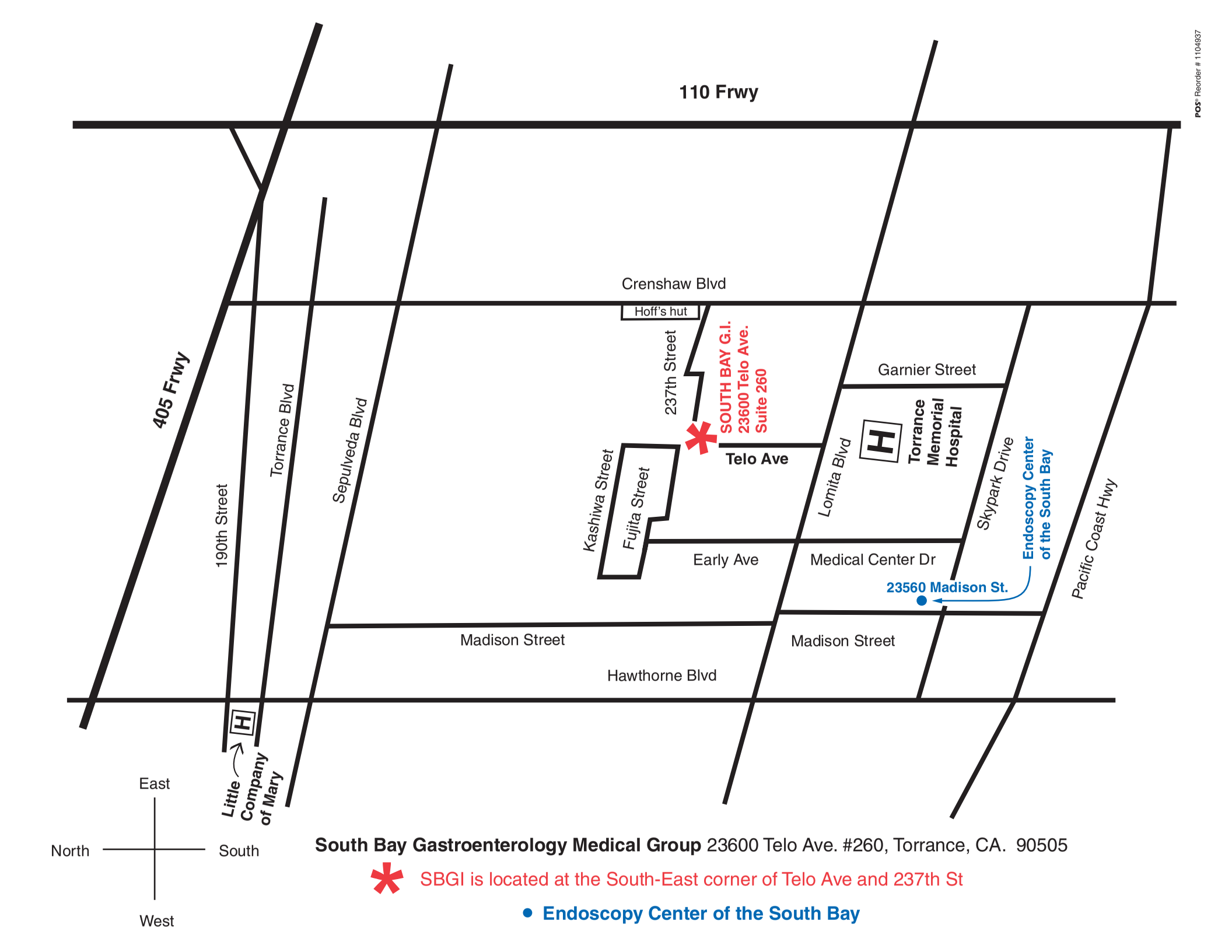
I, _____,
(print name)
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____
If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement

_____ **Date:**_____



South Bay Gastroenterology Medical Group 23600 Telo Ave. #260, Torrance, CA. 90505

* SBGI is located at the South-East corner of Telo Ave and 237th St

• **Endoscopy Center of the South Bay**