Susanna Chan, M.D.
Jerome Cohen, M.D., FACP
Mary Anmadian, MSN, ABNP-C
Gloria Sze, M.D.

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

Tonny M. Lee, M.D.
Oren Zaidel, M.D.
Minh Q. Nguyen, M.D.
Daniel D. Cho, 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 300 with the enclosed forms **COMPLETED** and please bring your insurance card(s) and Identification card.

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.
- ☐ Daniel D. Cho, M.D.
- ☐ Gloria Sze, M.D.
- ☐ Oren Zaidel M.D.
- ☐ Minh Q. Nguyen, M.D.
- ☐ Wendy Ard, PA-C
- ☐ Mary Anmadian, NP

PRACTICE LIMITED TO GASTROENTEROLOGY
23456 Hawthorne Blvd #300
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

[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 HISTORY FORM

[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)

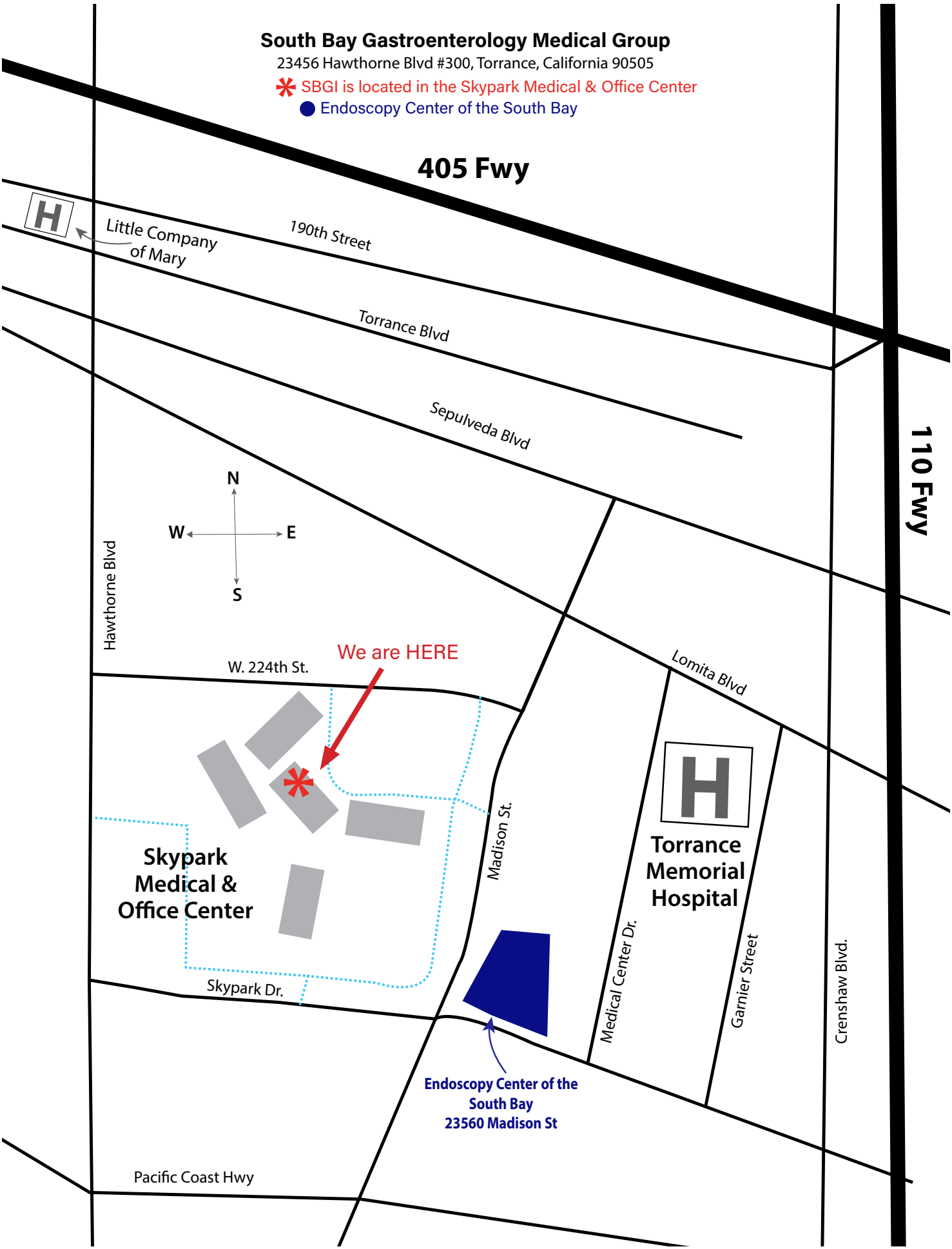
I, _____,
(print name)
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

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

Staff Witness seeking acknowledgement

_____ Date:_____


South Bay Gastroenterology Medical Group
23456 Hawthorne Blvd #300, Torrance, California 90505
SBGI is located in the Skypark Medical & Office Center
Endoscopy Center of the South Bay
405 Fwy
H
Little Company of Mary
190th Street
Torrance Blvd
Sepulveda Blvd
110 Fwy
N
W
E
S
Hawthorne Blvd
W. 224th St.
We are HERE
Lomita Blvd
Madison St.
Skypark Medical & Office Center
H
Torrance Memorial Hospital
Medical Center Dr.
Garnier Street
Crenshaw Blvd.
Skypark Dr.
Endoscopy Center of the South Bay
23560 Madison St
Pacific Coast Hwy

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

Patient Consent Form (Must Be Completed and Returned by Patient Prior To Treatment)
To the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, (Account Number:_____) understand that as part of my health care, South Bay Gastroenterology Medical Group and Endoscopy Center of the South Bay originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Health Information Exchange (HIE):

I understand that South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay may make my individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and or National Health Information Exchange and or state immunization registry.

I understand that the South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should the South Bay Gastroenterology Medical Group and the Endoscopy Center of the South Bay change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Can confidential messages be left on your answering machine or voicemail? [ ] YES [ ] NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:

Name:_____ Phone Number:_____
Name:_____ Phone Number:_____
Name:_____ Phone Number:_____

I wish to have the following restrictions to the use or disclosure of my health Information:_____
_____
_____

I fully understand and [ ] accept [ ] decline the terms of this consent.

Patients Signature:_____Date: _____

FOR OFFICE USE ONLY

[ ] Consent received by_____Date: _____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on (Date)_____

ENDOSCOPY CENTER OF THE SOUTH BAY
HIGH RISK QUESTIONNAIRE

NAME:		**DOB:**	**AGE:**
Primary Physician:		Phone No.:	Last Physical:
Do you see a Cardiologist? ☐Yes	Reason/Diagnosis:_____		☐No
If yes, who is your Cardiologist:		Phone No.:	
If you see a Cardiologist when was your last visit: _____			

PLEASE ANSWER FOLLOWING QUESTIONS CAREFULLY AS SOME HEART AND LUNG CONDITIONS MAY BE AT INCREASED RISK FOR COMPLICATIONS DURING SEDATION. THESE IMPORTANT QUESTIONS HELP US TO IDENTIFY ANY POSSIBLE RISK PRIOR TO YOUR PROCEDURE.

1)	PATIENT WEIGHT : _____ HEIGHT: _____	BMI: _____	
2)	Do you get short of breath when you walk one block ?	☐Yes	☐No
	If yes, why _____		
3)	Do you have a Defibrillator	☐Yes	☐No
4)	Have you had a Heart Attack within the last 6 mo.	☐Yes	☐No
5)	Have you had a Stroke within the last 6 mo.	☐Yes	☐No
6)	Do you use supplemental oxygen at home?	☐Yes	☐No
7)	Have you been treated for any of the following Cancers: Tongue, Mouth or Cheek	☐Yes	☐No
8)	Are you on Dialysis and/or Stage 4 renal failure ? If yes: Golytely Prep	☐Yes	☐No
08B)	Do you have chronic kidney disease? If Yes: \ If yes what stage?	☐Yes	☐No
09)	Do you get chest pain?	☐Yes	☐No
10)	If yes, please mark which definition explains your pain:		
	☐Pressure/compression ☐ Radiating pain down either arm ☐During exercise		
	☐After eating ☐Position change (worse or better) ☐Burning ☐Mid-line in Chest		
11)	Have you been diagnosed with Pulmonary Hypertension? (lungs)	☐Yes	☐No
12)	Have you had any Prior Cardiac Surgery or Diagnosis If yes when: _____	☐Yes	☐No
	Please check: o Heart Attack o Stents o Pacemaker o Congestive Heart Failure		
	o AFIB If yes: Blood Thinner_____ oCardiomyopathy (enlarged heart) o Heart Valve If yes: Antibiotics ordered_____		
12B)	Heart Conditions such as: High Blood Pressure- Please make sure to take your medication 2 hours prior to procedure. (If your B/P is not controlled your procedure may be cancelled)		
13)	Have you suffered a stroke and if so do you have any residual effects	☐Yes	☐No
14)	Have you been diagnosed with Sleep Apnea If yes: Send msg if BMI 38+	☐Yes	☐No
15)	Were you prescribed a CPAP machine	☐Yes	☐No
16)	Do you have any platelet disorders, (ie: thrombocytopenia)	☐Yes	☐No
17)	Do you have any clotting factor disorders? (i.e. Hemophilia, factor 5,7 10)	☐Yes	☐No
18)	Are you currently receiving Chemotherapy?	☐Yes	☐No
19)	Do you have any special medical or physical need that we should know before we schedule		
	your appointment?	☐Yes	☐No
20)	Are you on any prescribed blood thinners?	☐Yes	☐No
	If yes, For what reason? Name of blood thinner: _____		
	Scheduler Name: _____ Date: _____ EMR# _____		