



## Diagnostic Studies/Tests

None

Colonoscopy

When: \_\_\_\_\_

Endoscopy

When: \_\_\_\_\_

Sigmoidoscopy

When: \_\_\_\_\_

## Past or Present Medical Conditions

None

Anemia

When: \_\_\_\_\_

Asthma

When: \_\_\_\_\_

Crohn's Disease

When: \_\_\_\_\_

Cirrhosis

When: \_\_\_\_\_

Colon cancer

When: \_\_\_\_\_

Colon polyps

When: \_\_\_\_\_

Congestive  
Heart Failure

When: \_\_\_\_\_

Diabetes  
Mellitus

When: \_\_\_\_\_

GERD

When: \_\_\_\_\_

Gout

When: \_\_\_\_\_

Hepatitis

When: \_\_\_\_\_

Hyperlipidemia

When: \_\_\_\_\_

Hypertension

When: \_\_\_\_\_

## Previous Procedures

None

Appendectomy

When: \_\_\_\_\_

Bilateral hip  
replacement

When: \_\_\_\_\_

Back Surgery

When: \_\_\_\_\_

Laminectomy

When: \_\_\_\_\_

Mastectomy

When: \_\_\_\_\_

Vasectomy

When: \_\_\_\_\_

Testicular  
Surgery

When: \_\_\_\_\_

Colostomy

When: \_\_\_\_\_

Cardiac Surgery

When: \_\_\_\_\_

## Social History

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

### Marital Status

Single

Civil Union

Married

Unknown

Divorced

Other

Separated

Widowed

### Alcohol

None

Beer

Vodka

Wine

Rum

Tequila

Quantity

Frequency

### Caffeine

None

Coffee

Tea

Soda

Energy Drinks

Chocolate

### Tobacco

#### Smoking Status

Current every  
day smoker

Smoker, current  
status unknown

Current some  
day smoker

Unknown if ever  
smoked

Former smoker

Never smoker

**Drug Use**

None

Type	Quantity	Frequency
<input type="radio"/> Marijuana		
<input type="radio"/> Cocaine		
<input type="radio"/> Methamphetamine		
<input type="radio"/> IV Drugs		

**Exercise**

None

Type	Quantity	Frequency
<input type="radio"/> Running		
<input type="radio"/> Walking		
<input type="radio"/> Swimming		
<input type="radio"/> Biking		
<input type="radio"/> Free Weights		

**Family Medical History**

No knowledge of family history

No family history of  Colon cancer

Polyps

**Health Status**

Deceased/At Age

Family history of colon cancer

Family history of colon polyps

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Deceased/At Age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family history of colon cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family history of colon polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Pharmacy**

Name: \_\_\_\_\_

**Reviewed with**

Patient     Parent     Guardian     Not Present

**Signature**

Signature \_\_\_\_\_ Date \_\_\_\_\_



I have received, **upon request**, from Digestive Care Medical Center, a Notice of Privacy Practice for Health Information **OR** I understand my privacy rights and do not wish to receive a copy.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian (if under age 18) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Social Security Number \_\_\_\_\_

\_\_\_\_\_  
Mailing Address \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_

\_\_\_\_\_  
E-Mail Address (For the purpose of future participation in on-site research study **only**. If you are interested and qualify for such) \_\_\_\_\_  
**We will not give or sell this information to any other parties.**

I hereby authorize Digestive Care Medical Center and its' agents to leave any messages regarding my medical condition at the following phone number(s):

( ) \_\_\_\_\_ Home Mobile Office

( ) \_\_\_\_\_ Home Mobile Office

I designate the following family member(s) to whom my protected health information may be disclosed. I understand that I am not required to list anyone and may revoke this request at any time in writing.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Emergency Contact ( ) \_\_\_\_\_ Phone Number \_\_\_\_\_

**Digestive Care Associates**  
1000 Laurel Street  
San Carlos, Ca. 94070  
(650) 596-8800 fax (650) 596-8802

Financial Policy

To our patients,

We want our patients to be informed about our billing process. We will bill your insurance company for you. If you are scheduled for a procedure, such as a Colonoscopy or Upper Endoscopy, it may result in a bill from our office, Digestive Care Medical Center (our facility), and possibly a pathologist. You are responsible for any co-pays, coinsurance, deductible, and/or any other balance not paid by your insurance within our contracted rates. Please be aware there may be different benefits that apply for wellness, or screening, and for a medically necessary procedure (e.g. removal of polyps, dilating an area, etc.). You may be referred for a screening procedure, but once a polypectomy, biopsy or dilation is performed, it is no longer considered a screening procedure. Although we make every effort to check benefits in advance, you are responsible to know what your basic benefits are. If you are unsure, the customer service department of your insurance company can help you. Also, please note there is a \$300 fee for canceling your procedure within five business days.

Following a payment from your insurance company, we attempt to bill you monthly for three months. If we have not heard from you after these three months, your account will be considered delinquent and will be turned over to our collection agency.

I consent to necessary medical care and treatment by Scott Levenson, M.D. , Roger Kao, M.D., or Adrienne Nguyen, M.D.. I directly assign all medical benefits to Scott Levenson, M.D., Roger Kao, M.D., or Adrienne Nguyen, M.D. and understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name