GASTROENTEROLOGY

C.T HUNG., M.D & KATHLEEN LAUREL PA-C

PATIENT REGISTRATION FORM

Today's Date: ____/____/_____

★*PATIENT INFORMATION:*

Last Name: _____ *First Name:* _____ *Middle Initial:* _____

Date of Birth: _____/_____/_____ ☐ *Male* ☐ Female Social Security #: _____-_____-_____

Home Address: _____ *Apt/Ste #:* _____

City: _____ *State:* _____ *Zip:* _____

Phone☎#: _____-_____-_____ *Cellphone* ☎#: _____-_____-_____

Patient's Employers/School: _____ *Occupation:* _____ *work #:* _____

Marital Status: S M D W *Language:* _____ *Ethnicity:* _____ *Race:* _____

E-Mail Address: _____

★*INSURANCE INFORMATION:* ***Please provide original card and photo ID to the receptionist!***

Primary Insurance Carrier: _____ *ID:* _____ *Group:* _____

Subscriber Name (if different from patient name): _____ *Relationship:* _____

Subscriber D.O.B: _____/_____/_____ *Subscriber's Social Security#:* _____-_____-_____

Secondary Insurance: _____ *Insurance ID#:* _____

Subscriber's Name: _____ *Group#:* _____

★*EMERGENCY CONTACT:*

In case of emergency, who would you like us to contact?

Name: _____ *Relationship:* _____ ☎#: _____

Name: _____ *Relationship:* _____ ☎#: _____

Do you give our office permission to discuss your medical information with family members? YES NO

If yes, please provide name: _____ *Relationship:* _____ ☎#:(___) _____-_____

May we leave personal information on your answering machine at home? YES NO

★*Preferred pharmacy: Please provide name and location (Major Street Cross)*

_____

★*To whom may we thank for referring you to our office?* _____

★*Who is your Primary Care Physician: Dr.*_____ ☎#:(____) _____-_____

PATIENT MEDICAL HISTORY FORM

Last Name: _____ *First Name:* _____ *D.O.B:*_____/ . ___/_____
What are you being seen for today (briefly)? _____
Have you done any diagnostic testing (Labs, X-Ray, CT, or MRI) for this reason? *YES* *NO*

★***MEDICATIONS LIST:*** ***Please list all of prescribed / non - prescribed medications, vitamins, birth control, herbs, and / or weight loss medications.*** **If you are taking any medication, please indicate in the column above that you are not taking any medication.**

{Please Do not leave empty!}

Name	***Dose***	***Frequency***	***Name***	***Dose***	***Frequency***

☐ Not Taking Any Medications

★**Allergies:** ***Please list if you are allergic or have reactions / food / or other agents!*** **[DO NOT LEAVE BLANK]**

_____

★*MEDICAL HISTORY:*

☐ *Congenital Heart Disease*
☐ Heart Attack
☐ Hypertension
☐ Diabetes
☐ High Cholesterol
☐ Stroke
☐ Anemia
☐ Acid Reflux
☐ Coagulation (Bleeding / Clotting Disorder)
☐ Cancer_____
☐ Depression / Anxiety
☐ Alcoholism
☐ Liver Disease
☐ Thyroid Problem
☐ Constipation
☐ Diarrhea
☐ Smoking _____
☐ Last Pneumonia Vaccine _____/____/_____
☐ Last Influenza Vaccine _____/____/_____
☐ Last Mammogram Exam _____/____/_____
☐ Last Pap Smear Exam _____/_____/_____
☐ _____

★*PROCEDURE HISTORY:*

Procedure / Surgeries	*Year*	*Responsible Provider and Findings*
Colonoscopy		
EGD (Upper GI Endoscopy)		
Other _____		

Family History	***Colon Cancer*** ***YES NO***	***Breast Cancer*** ***YES NO***	***Esophageal / Stomach Cancer*** ***YES NO***
Father (Alive / Deceased)			
Mother (Alive / Deceased)			
Brother(s) / Sister(s) (Alive / Deceased)			

Office Policy

- ***New Patients.*** *Please provide your referral letter and insurance cards and medication list.*
- ***Established patients.*** *Our office will need updated list of your medications. Our office will not refill any medications that were prescribed by another Physician, unless the Doctor or Physician Assistant agrees to refill that medication on the day of your visit. We are only allowed to refill that medication one time only and then you will need to go back to your PCP for the next refill. Any changes in insurance, mailing address, last name, pharmacy and etc need to be updated in the system. Please inform our receptionist if there are changes.* ***IF YOUR INURANCE REQUIRED REFERRAL FROM YOUR PRIMARY PHYSICIAN, IT IS PATIENT 'S RESPONSIBLE TO KEEP REFERRAL CURRENT AND UP TO DATE.*** *Our office staff is not responsible for the currency of your referral.*
- *Our office policy is to* ***NOT refill*** *any medications over the telephone;* ***please have your pharmacy fax*** *us a refill request. And please allow our office 72 hours to return the refill request.* ***DO NOT WAIT UNTIL THE LAST MINUTE TO REQUEST A REFILL, BECAUSE YOU WILL NOT RECEIVE THE MEDICATIONS IN APPROPRIATE TIME.***
- *Medication will not be refilled for any patients who have not been seen by our office within the six months. You will need to make an appointment to be seen by the Doctor or Physician Assistant to refill medications or request refill from your primary physician.* ***WE DO NOT PRECRIBE ANY NARCOTIC MEDICATIONS.***
- *Due to a high volume of patients, next available appointment may be in several weeks. To ensure timely follow up and management of your condition and medical therapy, please make follow up appointment while in the office, or be sure to call several weeks before you are due to be seen.*
- *It is patient's responsibility to bring copies of lab result, x-rays, ultrasound, CT-scan, MRI, or any diagnostic tests that were not ordered by Dr. Hung or Kathleen Laurel PA-C. Failure to do so may result in reschedule appointment or prolonged wait time. We really appreciate your attention to these matters as it is important in providing a smooth and efficient office flow.*
- *All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, and American Express.*
- *Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges has for services not covered by your insurance company.*
- *Our Office is not responsible for any DISABLILTY PAPER WORK. But if there is some case where our office has to fill out paper work, there will be a fee of $25.*

By signing this policy, you here give C.T Hung permission to access your medication history. This Information will be used for the purpose of managing your prescriptions safely and to avoid any possible duplicate and adverse reactions. If you have questions concerning our policy, please discuss these with the Doctor, Physician Assistant or our office Manager.

I, _____ understand the policy of C.T HUNG M.D. INC regarding medication prescriptions and refills. I also have been advised and understand the potential complications of medications.

*Patient Signature:*_____ *Date:*_____

C.T. Hung, MD & Kathleen Laurel, P.A.-C

Gastroenterology & Internal Medicine

629 N. 13th Ave.
Upland, Ca 91786
(909) 985-2709

I understand that I am responsible for charges incurred for medical care rendered by C. T. Hung, MD or Kathleen Laurel, P.A.-C. I understand that my insurance company, my employer and other payers may have restrictions on reimbursement for medical care rendered by C.T. Hung, MD or Kathleen Laurel, P.A.-C. These restrictions might include pre-certification, use of designated facilities, frequency of test, non-covered services, deductibles, co-payments, and other requirements. I understand that it is my responsibility to comply with such restrictions, that I will be personally responsible for any charges not reimbursed by my insurance company or other payers.

I certify that all information given by me regarding payment by my insurance is correct. I understand that it is MANDATORY to notify C.T. Hung, MD or Kathleen Laurel, P.A.-C of any other party who may be responsible for reimbursement of my medical care (Section 1128B of the Social Security Act and 31 U.S.C, 3801-3812 provides penalties for withholding this information). I certify that all information given by me to bill my insurance and other payers is correct. I understand that payers may have time limits for filing claims, and providing incorrect and / or incomplete information may result in denial of reimbursement for which I will be personally responsible.

I authorize all payments for medical care rendered to me by C.T. hung, MD or Kathleen Laurel, P.A.-C to be assigned, transferred, and paid directly to C.T. Hung, MD. I will remit to C.T. Hung, MD immediately the full amount of any payments that may be received by me, a family, or custodian from my insurance company, my employer, or any other payer for medical care rendered to me by C.T. Hung, MD or Kathleen Laurel, P.A.-C.

_____ _____

PATIENT SIGNATURE *DATE*

C.T Hung, MD & Kathleen Laurel, P.A.-C

Gastroenterology & Internal Medicine

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(909) 985-2709

PATIENT COMMUNICATION CONSENT FORM

I agree to allow C.T. Hung MD and staff to contact me in the following methods regarding my private health information, evaluation and treatment. I authorized C.T. Hung MD and staff to leave messages for me when I am unavailable.

PREFFERED METHOD	*NUMBER/ADDRESS*	*MESSAGES*
_____ *Home Phone*	(____) _____-_____	☐*Yes* ☐*No*
_____ *Cell Phone*	(____) _____-_____	☐*Yes* ☐*No*
_____ *E-Mail*	(____) _____-_____	☐*Yes* ☐*No*

_____ _____

Patient Name Printed *Date*