

Rose T. Codini, MD
Gastroenterology & Hepatology

PATIENT INFORMATION SHEET

FIRST NAME: _____ **MIDDLE INT:** _____ **LAST NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME # _____ **WK#** _____ **CELL#** _____

BIRTHDATE: _____ **SS#** _____ **E-MAIL** _____

AGE: _____ **SEX:** F M **MARITAL STATUS:** S M W D OTHER

REFERRED BY: _____ **FAMILY DOCTOR:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SPOUSE/NEAREST RELATIVE: _____ **PHONE:** _____

SPOUSES EMPLOYER: _____ **BIRTHDATE:** _____ **SS#** _____

EMERGENCY CONTACT: _____ **RELATION/PHONE:** _____

PRIMARY INSURANCE

SECONDARY INSURANCE

COMPANY: _____

COMPANY: _____

ID# _____

ID# _____

GROUP# _____

GROUP# _____

INSURED: _____

INSURED: _____

CO-PAY: _____

CO-PAY: _____

I guarantee payment to Rose T. Codini, M.D. I authorize my insurance company(ies) to pay any and all charges rendered on my behalf directly to Rose T. Codini, M.D. I will be responsible for and will guarantee payment on any and all charges, which may not be paid or covered by my insurance company(ies). I understand payment in full may be required at the time of service (for your convenience we accept money orders, checks, cash, Visa, and MasterCard). I certify that the information given, including insurance coverage is complete and correct. I have read and understand Dr. Codini's cancellation fee policy. I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency. I understand the returned check fee is \$25.00.

SIGNATURE _____ **DATE** _____

Rose T. Codini, MD
Health Questionnaire

Patient Name: _____ **Date:** _____

Past Medical History:

Have you ever had (or have) the following: (Please check if "yes", leave blank if "no")

Heart Problems	Yes ___ explain: _____	Pacemaker / Stent / Valve	Yes ___	
Infectious Diseases	Yes ___ explain: _____	High Blood Pressure	Yes ___	
Respiratory Problems	Yes ___ explain: _____	Prolonged Bleeding	Yes ___	
Cancer	Yes ___ explain: _____	Thyroid Disease	Yes ___	
Liver Disease	Yes ___	Diabetes	Yes ___	
	High Cholesterol	Yes ___	Anemia	Yes ___

Other Medical Conditions/ Surgeries:

Drug Allergies: _____

History of Anesthesia (Reaction?): _____

Medications: _____
(Prescription, over the counter, & vitamins/supplements)

Patient Social History:

Marital Status:	Single: ___	Married: ___	Separated: ___	Divorced: ___	Widowed: ___
Use of Alcohol:	Never ___	Rarely: ___	Moderate: ___	Daily: ___	
Use of Tobacco:	Never ___	Quit: ___ (If so, When? _____)	Current packs/day: _____		
Use of Drugs:	Never ___	Type/ Frequency: _____			

(Recreational)

Family Medical History: Please List All Living And Deceased Family Members

	<u>Age</u>	<u>Diseases/Health Problems</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers/ Sisters	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Rose T. Codini, MD
24411 Health Center Dr., #430, Laguna Hills, CA 92653

Name: _____ Age: _____ Date: _____

Who referred you for this examination? _____

Have you ever had a Sigmoidoscopy or Colonoscopy? _____

If so, when? _____ What doctor? _____

Have you ever had an Endoscopy (EGD)?

If so, when? _____ What doctor? _____

Have you had any significant change in your bowel habits? _____

Do you regularly have diarrhea or constipation? _____

Do you have any rectal bleeding? _____

If so, is it bright red, burgundy, or maroon? _____

Do you see blood with the stool, on the toilet, or associated with a mucous discharge? _____

Do you have a family history of: Colon Cancer? _____

Colon Polyps? _____

Ulcerative Colitis? _____

Crohn's Disease? _____

If so, who? (List Maternal or Paternal) _____

Do you have a personal history of: Colon Cancer? _____

Colon Polyps? _____

Breast, Uterine, Ovarian, or Cervical Cancer? _____

Please add any additional information, if pertinent.

Please list the name(s) of doctor(s) that you would like us to send a report.

Rose T.Codini, MD
24411 Health Center Drive, Ste.# 430
Laguna Hills, Ca 92840

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - O.K. to leave message with spouse
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Written Communication
 - O.K. to mail to my home address
 - O.K. to mail to my work/office address
 - O.K. to fax to this number _____
 - O.K. to exchange information with referring doctors and treatment facilities
- Other _____

_____ Patient Signature	_____ Date
_____ Print Name	_____ Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. **Note: Uses and disclosures of PHI may be permitted without prior consent in an emergency.**

I authorize your office to disclose my health information to the following people if needed.

- | |
|----|
| 1. |
| 2. |

Rose T. Codini, MD
24411 Health Center Drive, Ste. 430
Laguna Hills, Ca 92653
949-452-3933.

Cancellation Policy

Time has been specifically reserved for your office visits and procedures. Due to our high patient volume and long patient wait list, you are required to give us at least 72 hour (3 days) notice if you cancel your procedure (EGD or Colonoscopy). This will enable us to schedule another patient and follow the required procedure preparation.

If you do not cancel your PROCEDURE at least 3 Days before your scheduled date, you will be charged a \$200.00 cancellation fee.

You are required to give us at least a 24 hour notice if you wish to cancel an office visit.

If you fail to cancel your OFFICE VISIT before a 24 hour period, you will be charged a \$75.00 cancellation fee.

These fees are non-refundable, even if you decide to reschedule.

We confirm office visits 1-2 days before the scheduled appointment. This is a courtesy call only.

It is your responsibility to call us 3 days before your procedure or 24 hours before an office visit if you are unable to keep your scheduled appointment. If an emergency arises and you need to cancel your procedure after hours, we ask that you call our office and have the doctor on-call paged for notification.

Cancellation Agreement:

Effective: January 1, 2008

I understand Dr. Codini's Cancellation Policy above and agree to follow Dr. Codini's office policy.

Patient Name (Please Print)

Patient Signature

Date

Office Staff: