BLACKHAWK CENTER FOR DIGESTIVE HEALTH
JEFFREY C. G. MARK, M.D.

Practice limited to Gastroenterology

PATIENT REGISTRATION FORM

Date _____

Patient's Name _____ Social Security Number _____

Age ____ Date of Birth _____Gender – M / F Marital Status _____ *Ethnicity (circle one, if applicable): Hispanic / Non-White Hispanic

Race: *required by CMS, Meaningful Use
__White
__ African American
__Asian
__ American Indian / Alaska Native
__ Native Hawaiian /Pacific Islander
__ Other

*Preferred Language Spoken: _____*Secondary Language (if applicable):_____

Address _____
STREET CITY STATE ZIPCODE

Home Telephone (_____) _____ CellTelephone (_____) _____ Fax # (_____) _____

Occupation _____ Employer or Parent's Name (if minor) _____

Employer Address _____
STREET CITY STATE ZIPCODE

Employer Telephone (_____) _____Email Address _____

Please note this section is **REQUIRED.**

Emergency Contact Person _____**Telephone** (_____) _____ **Relationship** _____

Occupation _____ **Work Telephone** (_____) _____

Your Primary Insurance _____ Type – PPO /EPO / HMO**ID #** _____**Group #** _____

If not PPO - What is your Primary IPA: _____Secondary IPA:_____
IPA_____
Please provide copy of insurance card
IF YOU ARE NOT THE PRIMARY CARDHOLDER, PLEASE REFER TO "RESPONSBILE PARTY"

Secondary Insurance _____ Type – PPOEPO HMO**ID # _____Group #**
_____

*PRIMARY SUBSCRIBER'S NAME*_____*Responsible Party's Name*_____ *Relationship to Patient* _____

*Signature of Responsible Party*_____*Date of Birth* _____*Social Security Number* _____

Address _____
STREET CITY STATE ZIPCODE

Your Pharmacy _____ Telephone (_____) _____ Location: _____

May we leave messages at the telephone numbers listed above? YES NO

Household Members' Names: 1) _____ 2) _____ 3) _____ 4) _____

How did you hear about our practice? _____

- I hereby certify that the above information is true.
- I hereby consent to medical treatment by Blackhawk Center for Digestive Health.
- I hereby authorize Blackhawk Center for Digestive Health to release any information acquired in the course of my examination to any referring physician/facility should such a referral be necessary for my care.
- I accept full responsibility for all charges to this or subsequent treatment. This supersedes all other contracts and/or agreements.
- I acknowledge receipt of the **Notice of Health Information Privacy Practices** for Blackhawk Center for Digestive Health.

Signature of Patient or Legal Guardian_____ Date _____

Gastroenterology Consultation Health History Questionnaire

Patient's Name: _____ Referring Physician: _____

Fax #: _____

Reason for Referral: _____

_____

_____

NOTE Please complete this page as well as the next immediate page. Also, please bring your authorization number at the time of your visit if required by your insurance carrier.

Date of Birth: _____/_____/_____ Personal Information: ___ Married ___ Divorced ___ Single

Occupation: _____ ___ Separated ___ Widowed

For all of the following questions, if none, please mark 'none'.

Major Events **(**Hospitalizations/Surgeries) - list all illnesses or operations and year performed:

_____

_____

_____

Ongoing medical problems - list all illnesses you have been diagnosed with or currently managing (hypertension, diabetes mellitus):

_____

_____

Allergies(list all medications you're allergic to):

_____

_____

Medications(list all medication, birth control pills or vitamins you take including over-the-counter drugs such as Advil, Pepcid AC, etc.) :

_____

_____

Preventive Care (list all vitamins, supplements you are currently taking):

_____

Nutrition History (any specific diet or lifestyle changes):_____

_____

Social History:

Smoking (Y/N) - Packs per week:____ Alcohol (Y/N) - Drinks per week:____ Drug use:_____

Developmental History: circle those that applies: ADD / ADHD / Autism / Developmental Delays / Down Syndrome / Learning Disability Other:_____

_____

Vaccination History:

Have you recently (last two years) received seasonal influenza (flu) vaccine?

Y/N, if yes, please state when (month, year): _____

Have you received the hepatitis vaccination (Hep B)?

Y/N, if yes, please state when (month, year): _____

Have you received a vaccination for pneumonia (pneumococcal vaccine or Prevnar 13)?

Y/N, if yes, please state when (month, year): _____

Current Health of Family

Relation

Father _____

Mother _____

Siblings _____

_____

Spouse _____

Children _____

_____

Specific Family History

Gallstones _____

Polyps _____

Pancreatitis _____

Ulcer _____

Liver Disease _____

Cancer _____

Name: _____

Please mark all applicable conditions/symptoms you have experienced:

(indicate if you have experienced symptoms in the past, present or both)

General

___ chronic fatigue
___ weight loss (amount _____ lbs since when? _____)
___ fever
___ anemia
___ bruise easily/excessive bleeding
___ cancer (what kind? _____)
___ diabetes (when diagnosed? _____)
___ thyroid disease

Gastrointestinal

___ diarrhea
___ heartburn
___ nausea
___ blood in stool
___ liver disease
___ difficulty swallowing
___ constipation
___ stomach cramps
___ vomiting
___ bloating
___ gas

Urinary

___ urinary tract infections
___ kidney stones
___ decrease in force of urine flow
___ blood in urine
___ urination at night (more than twice)
___ painful urination

Ears, Eyes, Nose & Throat

___ ringing in ears
___ ear infections
___ dizziness
___ poor vision
___ glaucoma
___ sinus troubles
___ hoarseness
___ eye infections
____ cataracts

Bones & Joints

___ arthritis/rheumatism
___ back pain (chronic/recurrent)
___ gout
___ osteoporosis

Lungs

___ pneumonia
___ asthma
___ shortness of breath
___ bronchitis
___ cough

Neurological/Psychiatric

___ stroke
___ numbness or tingling
___ headaches (frequent)
___ memory loss
___ depression
___ panic attacks
___ tremor/hands shaking
___ migraine
___ seizures
___ anxiety

Heart

___ chest pain
___ high blood pressure
___ irregular heart beat
___ palpations
___ ankle swelling
___phlebitis (blood clot)

Skin

___ rashes
___ allergic reactions
___ hives

AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL RECORDS

Name of Patient: _____

Date of Birth: _____

PERSONS AUTHORIZED TO RELEASE RECORDS:

_____ _____

_____ _____

_____ _____

This authorization is in compliance with state and federal laws pertaining to the request/release of patient medical records. I, the patient, hereby authorize all records requested be sent to:

Blackhawk Center for Digestive Health
Jeffrey C.G. Mark, M.D.
111 Deerwood Road, Suite #168, San Ramon, CA 94583
Tel: (925) 736-8228
Fax: (925) 736-8882

DESCRIPTION OF INFORMATION REQUESTED:

_____All medical records

_____Most recent progress notes, labs/pathology, reports, and medications

_____Only the following types of medical information and/or only treatments/reports on the specified dates:

_____

Signature of Patient or Legal Guardian_____ Date _____