

Diplomate of the American Board of
Gastroenterology

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Gastrointestinal & Liver disease
EGD COLONOSCOPY
Fax (509)946-3737

Phone (509)946-3636

Primary/Family Doctor _____

PATIENT NAME: _____ Preferred Name: _____ Date of Birth: _____

Address _____ Marital Status: M _____ D _____ S _____ W _____ SEX _____ Age _____

PATIENT SOC SEC # _____

RACE: _____ ETHNICITY: _____ DECLINED: _____

*Phone Number: _____ Cell _____ Work _____ Home _____ *LEAVE DETAIL VOICE MAIL: YES _____ NO _____

*PATIENT EMPLOYER: _____ *EMPLOYER PHONE NUMBER: _____

*SPOUSE NAME: _____ *DATE OF BIRTH: _____ *Phone # _____

*Who May we Thank for This Referral: Friend _____ Internet _____ Dr Yang Website _____ Yellow Page _____ Other _____

*PERSON RESPONSIBLE FOR THE ACCOUNT: *SOC SEC # _____

Name: _____ Relationship to Patient: _____ Phone Number: _____

Address _____

*Employer: _____ *Employer Phone Number: _____

*Nearest Relative or Friend Name: _____ Relationship: _____ Phone Number: _____

*Authorized Persons (Who do you Authorize to discuss or receive your Medical Record)

Name _____ Relationship to Patient _____ Phone Number _____

Address _____

PRIMARY INSURANCE NAME: _____ *SECONDARY INSURANCE NAME: _____

Policy Holder Name _____ Policy Holder Name _____

Policy Number _____ Policy Number _____

Group Number _____ DATE OF BIRTH: _____ Group Number _____ DATE OF BIRTH: _____

PATIENT FINANCIAL RESPONSIBILITY TO PAY: PLEASE READ AN SIGN.

1. Your Insurance Coverage is a contract between you and your Insurance company. This Office will Submit Claims to your Carrier as a **CONVENIENCE TO YOU**
2. When Insurance Payment is received and patient responsibility is verified, Remaining Balance will be billed to you.
Patient's Responsibility will be Due Full within 21 Days of Receipt.
3. I UNDERSTAND THAT, If My Balances are not paid in Full by Third Statement (Final Notice), My Account will be turned over to Collection Agency.
4. \$30 NSF Charge will be added to my account in case of Insufficient Fund.

Please understand Dr Yang Does not provide services for Emergency Room visits or Hospital admissions which are not related to Gastrointestinal, Liver Or Pancreas problems. This information provided is true to the best of my knowledge. I authorize release of information to my Insurance Company and My primary care physician. I understand that Dr. Yang is consulting for my primary care physician and I should Call My Primary Physician for Other Medical Problems.

SIGNATURE: _____

DATE: _____

**CONSENT FOR RELEASE OF INFORMATION
FOR TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS**

I, _____, hereby authorize Hoyeol Yang, MD, to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Hoyeol Yang, MD, can refuse to treat me.

I have been informed that Hoyeol Yang, MD, has prepared a notice ("Notice") which more fully describes the use and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Hoyeol Yang, MD, in writing, but if I revoke my consent, such revocation will not affect any actions that Hoyeol Yang, MD, took before receiving my revocation.

I understand that Hoyeol Yang, MD, has reserved the right to change his privacy practice and that I can obtain such changed notice upon request.

I understand that I have the right to request that Hoyeol Yang, MD, restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or healthcare operations. I understand that Hoyeol Yang, MD, does not have to agree to such restrictions, but that once such restrictions are agreed to, Hoyeol Yang, MD, must adhere to such restrictions.

Signature of patient or patient's representative
(Form MUST be completed prior to signing)

Date

Printed name of patient or patient's representative

Relationship to the patient

Name: _____ Referring Physician: _____ Today's Date: ___/___/___

Age: ___ Birth Date: ___/___/___ Weight: ___ Height: ___ Reason for visit: _____

PLEASE INCLUDE ANY OVER THE COUNTER MEDICATIONS & VITAMINS SUCH AS ASPIRIN, IBUPROFEN, ETC.

MEDICATIONS	DOSAGE	TIMES PER DAY

IF YOU HAVE MORE THEN 5 MEDICATION PLEASE ATTACHED LIST OR CONTINUE ON OTHER SIDE OF PAGE

MEDICATION ALLERGIES	REACTION & SEVERITY	Are you allergic to any of the following?		
		<input type="checkbox"/> LATEX	<input type="checkbox"/> NUTS	
		<input type="checkbox"/> SHELL FISH	<input type="checkbox"/> TAPE	
		<input type="checkbox"/> EGGS	<input type="checkbox"/> MILK	<input type="checkbox"/> WHEAT

IF YOU HAVE MORE THEN 3 ALLERGIES PLEASE ATTACHED LIST OR CONTINUE ON OTHER SIDE OF PAGE

PAST MEDICAL HISTORY

CHECK ANY CONDITION YOU HAVE HAD IN THE PAST

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hemorrhoid	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Colonic polyp	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Angina	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia, hiatal	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Hernia, umbilical	<input type="checkbox"/> Sleep Apnea-CPAP use: Yes/No
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hernia, groin	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes Zoster	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Gallstone disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Thyroid- Hypo/Hyper
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> GERD	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney disease	<input type="checkbox"/>
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Migraine headache	<input type="checkbox"/>

HISTORY OF SURGERIES, HOSPITALIZATIONS, AND PROCEDURES

YEAR	TYPE OF SURGERY OR PROCEDURE	YEAR	TYPE OF SURGERY OR PROCEDURE

VACCINATION HISTORY	DATE	DATE	DATE
YEARLY FLU VACCINE			
HEPATITIS A			
HEPATITIS B			
PNEUMOVAX			

NAME: _____

DATE: ___/___/___

FAMILY HISTORY

FILL IN INFORMATION ABOUT YOUR FAMILY

RELATION	HEALTH STATUS OR CAUSE OF DEATH	MEDICAL CONDITIONS	AGE OF DEATH IF DECEASED
FATHER			
MOTHER			
BROTHER			
SISTER			
OTHER			

CHECK IF YOUR BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING

PLEASE LIST IF EACH RELATIVE IS FROM YOUR MOTHER'S OR YOUR FATHER'S SIDE OF THE FAMILY

<input type="checkbox"/> INFLAMMATORY BOWEL DISEASE		<input type="checkbox"/> HEART DISEASE	
<input type="checkbox"/> ULCERATIVE COLITIS		<input type="checkbox"/> HEART ATTACK	
<input type="checkbox"/> CROHN'S DISEASE		<input type="checkbox"/> HIGH BLOOD PRESSURE	
<input type="checkbox"/> PANCREATITIS		<input type="checkbox"/> DIABETES	
<input type="checkbox"/> COLON CANCER		<input type="checkbox"/> HEPATITIS	
<input type="checkbox"/> COLON POLYP(S)		<input type="checkbox"/> OTHER	
<input type="checkbox"/> CELIAC SPRUE		<input type="checkbox"/> OTHER	

HAVE YOU EVER HAD A BLOOD TRANSFUSION? NO YES IF YES DATE: ___/___/___

MARITAL STATUS: M___ D___ S___ W___ **NUMBER OF CHILDREN:** ___ **OCCUPATION:** _____

HEALTH HABITS

<input type="checkbox"/> CAFFEINE	<input type="checkbox"/> COFFEE ___ CUPS/DAY	<input type="checkbox"/> SODA ___ CUPS/DAY	<input type="checkbox"/> TEA ___ CUPS/DAY
<input type="checkbox"/> TOBACCO	PPD ___	HOW MANY YEARS ___	QUIT DATE ___
<input type="checkbox"/> CHEW	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> BEER	<input type="checkbox"/> WINE	<input type="checkbox"/> LIQUOR
	FREQUENCY: _____ PER DAY/WEEK		
<input type="checkbox"/> DRUGS	<input type="checkbox"/> PAST USE	<input type="checkbox"/> CURRENT USE	<input type="checkbox"/> NEEDLE USE
<input type="checkbox"/> MARIJUANA	<input type="checkbox"/> PAST USE	<input type="checkbox"/> CURRENT USE	

SYMPTOMS

<input type="checkbox"/> Fever	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Bloating	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chest Pain	PAIN/WEAKNESS OR NUMBNESS IN
<input type="checkbox"/> Chills	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bowel Habit Change	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Nausea	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Dyspnea on Exertion	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Feeling of Lump in Throat	<input type="checkbox"/> Neck
<input type="checkbox"/> Headache	<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Vomiting with Blood	<input type="checkbox"/> Gas	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Extremities
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Coughing	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Rash	<input type="checkbox"/> Joints

*****PATIENT'S FINANCIAL RESPONSIBILITY *****
AND AGREEMENT TO PAY

Your Insurance Company requires Dr. Yang to Collect Co-Pay At time of Visit to our office. Hoyoel Yang, M.D., P.S., Will Gladly Submit Your Insurance Claims on Your Behalf.

As We Receive Payment from insurance Company for Each Date of Services Provided By Hoyoel Yang, M.D., P.S. Remaining Balance Will Be Billed to You.

AND WILL BE DUE IN FULL WITHIN 21 DAYS OF RECEIPT.

PLEASE CALL YOUR INSURANCE COMPANIES (1ST INSURANCE, 2ND INSURANCE)

TO VERIFY THAT HOYEOL Yang, M.D., P.S. IS Currently in Network Provider of your Insurance Companies and Verify **Your Responsibility Amount for Your Copayments and CO-Insurances, Yearly or with New Insurances.**

ALSO VERIFY IF AUTHORIZATION OR REFERRAL IS NEEDED FOR THE SERVICES.

INCORRECT INSURANCE INFORMATIONS AND NO AUTHORIZATION OR REFERRAL PROVIDED TO THE PRACTICE OF Hoyoel Yang, M.D., P.S. YOU WILL BE BILLED FOR THE FULL AMOUNT.

By Signing below you acknowledge that You are Responsible for the Entire Billing from Hoyoel Yang, M.D., P.S.

SIGNATURE OF RESPONSIBILITY PARTY: _____ DATE: _____