Diplomate
American Board of Gastroenterology

Hoyeol Yang MD PS

98 Columbia Point Drive
Richland, WA 99352
Phone: 509-946-3636
Fax:509-946-3737

Gastrointestinal & Liver Disease
EGD Colonoscopy Sigmoidoscopy

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?		
		□ LATEX	□ NUTS	
		□ SHELL FISH	□ TAPE	
		□ EGGS	□ MILK	□ 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

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

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			
HEPATATIS 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			
□ INFLAMATORY BOWEL DISEASE		□ HEART DISEASE	
□ ULCERATIVE COLITIS		□ HEART ATTACK	
□ CROHN'S DISEASE		□ HIGH BLOOD PRESSURE	
□ PANCREATITIS		□ DIABETES	
□ COLON CANCER		□ HEPATITIS	
□ COLON POLYP(S)		□ OTHER	
□ CELIAC SPRUE		□ 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	
□ **CAFFEINE**	□COFFEE ____ CUPS/DAY □ SODA ____ CUPS/DAY □TEA ____ CUPS/DAY
□ **TOBACCO**	PPD ____ HOW MANY YEARS ____ QUIT DATE ____
□ **CHEW**	□YES □NO
□ **ALCOHOL**	□ BEER □ WINE □ LIQUOR FREQUENCY: _______ PER DAY/WEEK
□ **DRUGS**	□ PAST USE □CURRENT USE □NEEDLE USE
□ **MARIJUANA**	□ PAST USE □CURRENT USE

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

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PATIENT INFORMATION

Name: ____________________ Preferred Name: ____________________
Address: ____________________ Date of Birth: ____________________
____________________ Sex: _______ Referred by: ____________________
____________________ Marital status: M_____ D_____ S_____ W______
Home Phone: ____________________ Patient's SS#: ____________________
Work Phone: ____________________ Patient's Employer: ____________________
Spouse's Name: _____________Work Phone: _________ Occupation: ____________________

WHOM MAY WE THANK FOR THIS REFERRAL: Friend: __ Web Site: __ Yellow Pages: __ Other: _________

ACCOUNT INFORMATION-Responsible for account

Name: ____________________ Relationship to patient: ____________________
Address: ____________________ Phone: H: ______________ W: ______________

NEAREST RELATIVE OR FRIEND

Name ____________________ Relationship ______________ Phone ________

AUTHORIZED PERSONS (Who do you wish to be able to discuss or to receive your medical records)

Name: ____________________ Relationship to patient: ____________________
Address: ____________________ Phone: H: ______________ W: ______________

INSURANCE PLANS

PRIMARY PLAN:____________________
Ins. or Medicare ID#:____________________
Ins. Group#:____________________
Policyholder: ____________________
Date of Birth of Policyholder: ____________________

SECONDARY PLAN:____________________
Ins. or Medicare ID#:____________________
Ins. Group #:____________________
Policyholder: ____________________
Date of Birth of Policyholder: ____________________

PLEASE READ: In order to prevent misunderstandings about our fees and your medical insurance, we would like our patients to know that:

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. However, once insurance payment is received and patient responsibility is verified we will provide a patient statement to you via mail. All fees are the patient's responsibility and are due in full within thirty days of receiving a statement.
2. I understand that a $20 delinquent fee will be charged to my account if it is turned over to a collection service. This will be done when no payment is received within 90 days.
3. A $30 charge will be added to my account in case of NSF check.

Please understand also that 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 care physician for other medical problems.

SIGNATURE: ____________________________ DATE: ____________________

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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