

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_  
Marital status: M \_\_\_\_\_ D \_\_\_\_\_ S \_\_\_\_\_ W \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Patient's SS#: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_  
Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

**WHOM MAY WE THANK FOR THIS REFERRAL:** Friend: \_\_ Web Site: \_\_ Doctor: \_\_\_\_\_ Other: \_\_\_\_\_

**ACCOUNT INFORMATION-Responsible for account**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: H: \_\_\_\_\_ C: \_\_\_\_\_

**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: \_\_\_\_\_ C: \_\_\_\_\_

**INSURANCE PLANS**

<b>PRIMARY PLAN:</b> _____	<b>SECONDARY PLAN:</b> _____
Ins. or Medicare ID#: _____	Ins. or Medicare ID#: _____
Ins. Group#: _____	Ins. Group #: _____
Policyholder: _____	Policyholder: _____
Date of Birth of 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: \_\_\_\_\_

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