MEDICAL HISTORY

First Name_____ Last Name_____
DOB _____Age _____ Current Height: _____ Weight: _____
How did you hear about us? Referring Physician _____
Internist/Primary Physician _____
Pharmacy _____ Pharmacy Phone# _____

CHIEF COMPLAINT- Check all that apply

□ Colonoscopy screening	□ Abdominal pain	□ Change in bowel habits	□ Gallbladder/Liver problems
□ Nausea/Vomiting	□ Bloating/Gas	□ Rectal bleeding	□ Blood in stool
□ Painful swallowing	□ Diarrhea	□ Weight loss	□ History of Barrett's
□ Heartburn	□ Constipation	□ Abnormal imaging/labs	□ Other _____

□ **Abdominal pain** if yes, for how long? _____
Severity: 1 (mild)-(10 severe)? _____
What improves the pain? _____
What worsens the pain? _____
□ **Bloating** if yes, for how long? _____
Circle all that apply: Worse with food/Excessive burping/Excessive gas/Recent antibiotics or travel.
□ **Heartburn** if yes, for how long? _____
Circle all that apply: Daily/Not often/Cough/Hoarseness/Awaken at night.
Relieved with medications? _____ If so, which meds? _____
□ **Diarrhea** if yes, for how long? _____
Circle all that apply: Blood present/Mucus present/Antibiotics in the past 3 months/Recent travel.
Number of bowel movements per day? _____
□ **Constipation** if yes, for how long? _____
Circle all that apply: Require laxatives or enemas/Sense of incomplete emptying/Straining.
Number of bowel movements per week without laxatives? _____ and with laxatives? _____
□ **Rectal Bleeding** if yes, for how long? _____
Circle all that apply: Blood on toilet paper/Blood in toilet/Blood in stool/Rectal pain
□ **Painful swallow** if yes, for how long? _____
Circle all that apply: Liquids/Solids/Both. Do you take medication/s supplement at bedtime? _____
□ **Food stuck in esophagus** if yes, for how long? _____
Circle all that apply: Liquids/Solids/Both.
□ **Vomiting/Nausea** if yes, for how long? _____
Circle all that apply: Food/Bile/Both
□ **Any weight change in the last 6 months**? □ YES □ NO If yes, □ Loss or □ Gain. How many pounds? _____

PREVIOUS TESTING- Check all that apply

□ Colonoscopy	□ Wireless Capsule Endoscopy	□ Abdominal Ultrasound	□ Urea breath test (H.pylori)
□ Upper Endoscopy	□ MRI	□ Pelvic/Vaginal Ultrasound	□ Stool test
□ Sigmoidoscopy	□ CT Scan	□ Lactulose breath test (SIBO)	□ Other _____

Consultation with another gastroenterologist? (please list)
_____

Most Recent Upper Endoscopy _____ _____ _____
Date Physician General Findings

Most Recent Colonoscopy _____ _____ _____
Date Physician General Findings

CURRENT/PAST MEDICAL HISTORY □ None

GASTROINTESTINAL
□ IBS(irritable bowel syndrome)
□ GERD/Heartburn
□ Gastritis
□ H. pylori
□ Peptic ulcer
□ Colon polyps
□ Hemorrhoids
□ Diverticulosis
□ Diverticulitis
□ Gallstones
□ IBD-Ulcerative Colitis
□ Pancreatitis
□ Chronic constipation
□ GI bleeding

HEART
□ High blood pressure
□ Heart attack
□ Angina
□ Congestive heart failure
□ Palpitations
□ Atrial fibrillation
□ High cholesterol
□ Heart valve disease
□ Coronary artery disease

LIVER
□ Cirrhosis
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Elevated liver test
□ Jaundice
□ Fatty liver

RENAL
□ Kidney stones
□ Kidney failure

NEUROLOGICAL
□ Stroke
□ Seizure
□ Migraines
□ Headaches

□ **RESPIRATORY**
□ COPD/Emphysema
□ Asthma
□ Tuberculosis
□ Sleep Apnea
□ Collapsed lung

CANCER
□ Colon cancer
□ Esophageal cancer
□ Stomach cancer
□ Breast cancer
□ Prostate cancer
□ Liver cancer
□ Leukemia

ENDOCRINOLOGY
□ Diabetes type I
□ Diabetes type II
□ Hypothyroidism
□ Hyperthyroidism

INTEGUMENTARY
□ Skin cancer
□ Melanoma
□ Vitiligo
□ Eczema

MUSCULOSKETAL
□ Fibromyalgia
□ Rheumatoid arthritis
□ Raynaud's
□ Lupus
□ Sjogrens
□ Scleroderma
□ Gout

PSYCHOLOGICAL
□ Bipolar
□ Anxiety
□ Depression
□ OCD
□ Schizophrenia

BLOOD
□ Von Willebrand disease
□ Hemophilia
□ Bleeding or clotting

OTHER
_____

SURGICAL HISTORY □ None

GASTROINTESTINAL
□ Appendix
□ Hiatal hernia repair (esophagus)
□ Gallbladder
□ Gastric bypass
□ Gastric resection
□ Colonoscopy
□ Upper Endoscopy (EGD)
□ ERCP

CARDIAC
□ Heart stent placement
□ CABG (coronary artery)
□ Pacemaker
□ Defibrillator
□ Abdominal Aneurysm repair
□ Heart Valve replacement

GENITORURINARY
□ TURP
□ Bladder removal
□ Kidney transplant
□ Kidney removal
□ Prostatectomy

GYNECOLOGICAL
□ Hysterectomy
□ Ovary removal
□ C-section
□ Breast biopsy
□ Mastectomy

OTHER
□ Tonsillectomy
□ Thyroidectomy

MEDICATIONS- List ALL prescriptions, supplements, and over the counter medications

Medication	Dose	Medication	Dose
1._____	_____	6._____	_____
2._____	_____	7._____	_____
3._____	_____	8._____	_____
4._____	_____	9._____	_____

ALLERGIES: □ No Known Drug Allergies □ Iodine □ Sulfa □ Aspirin □ Penicillin □ Other: _____

ISSUES WITH ANESTHESIA □ No □ Yes If yes please explain_____

FAMILY HISTORY- Check all diseases that have occurred in your family and **indicate family member** □ None

	FAMILY MEMBER		FAMILY MEMBER
□ Crohn's Disease	_____	□ Liver Disease	_____
□ Ulcerative Colitis	_____	□ Hemochromatosis	_____
□ Peptic Ulcer Disease	_____	□ Gallstones/Gallbladder disease	_____
□ Celiac Disease	_____	□ Pancreatitis	_____
□ Colon Polyps	_____	□ Breast Cancer	_____
□ Stomach Cancer	_____	□ Uterine/Ovarian Cancer	_____
□ Esophageal Cancer	_____	□ Cervical Cancer	_____
□ Pancreatic Cancer	_____	□ Renal/Ureteral Cancer	_____
□ Colon/Rectal Cancer	_____	□ Other	_____
□ Small bowel Cancer	_____		

SOCIAL HISTORY

SMOKING: Do you **currently** smoke? □ Yes □ No If yes, how many packs per day? _____
Smoked in the past? □ Yes □ No If yes, when was your quit date? _____

ALCOHOL: Do you drink alcohol? □ Yes □ No If yes, how many times in a week? _____
How many drinks each time? _____

DRUGS: Do you use illicit drugs? □ Yes □ No If yes, how often? _____
Type: □ Cocaine □ Ecstasy □ Heroin □ Marijuana □ Pain medications □ Other IV Drugs _____

SEXUAL ORIENTATION: □ Straight □ Gay □ Lesbian □ Bisexual □ Other

GENERALIZED REVIEW OF SYMPTOMS □ None

CONSTITUTIONAL
□ Decreased appetite
□ Excessive fatigue
□ Night Sweats
□ Weight Loss

CARDIOVASCULAR
□ Irregular heartbeat
□ Leg swelling
□ Poor exercise tolerance
□ Chest Pain

ENDOCRINE
□ Excessive thirst
□ Cold intolerance
□ Menopause
□ Weight gain (10+ lbs)
□ Weight loss

PSYCHIATRIC
□ Suicidal Intention
□ Trouble Sleeping
□ Depression

NEUROLOGICAL
□ Dizziness
□ Headaches
□ Numbness/Tingling
□ Seizures

MUSCULOSKELETAL
□ Back pain
□ Recent injury
□ Swelling

HEMATOLOGICAL
□ Anemia
□ Bleeding and/or bruising
□ Blood transfusion

URINARY
□ Frequency of urination
□ Loss of bladder control
□ Burning with urination

ENT
□ Dentures/Partials
□ Ear pain/Ringing
□ Eye pain/Blurred vision
□ Hearing loss
□ Hoarseness
□ Inability to smell
□ Neck Lumps

RESPIRATORY
□ Chronic cough
□ Sleep Apnea
□ Shortness of breath
□Wheezing/Asthma

SKIN
□ Bruising
□ Itching
□ Jaundice
□ Rash
□ Skin cancer
□ Tattoo

REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Ethnicity:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Home phone number:		Cell phone number:				
Email Address:		Social Security number:				
Address:						
City:	State	Zip Code:				
Occupation:		Employer: Employer phone number:				
Emergency Contact:		Relationship: Phone number:				
Insurance Co:						
Subscriber Name/DOB:						
□ I **do** □ I **do not** give permission to leave relevant medical information on my answering machine or voice mail.						
□ I **do** □ I **do not** want my medical information mailed to my house address on file.						

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/ambulatory surgery center and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection Agency. In the event that your account is referred to an Agency, you will be responsible for all attorney's and/or collection fees.

I directly assign all medical/surgical benefits to PEYTON P. BEROOKIM, M.D., INC. and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If I receive a check from my insurance, I agree to immediately endorse the back of the check to Peyton P.Berookim, M.D., Inc. and send it to the medical office at 150 N Robertson Blvd. Suite 115, Beverly Hills, CA 90211. I understand that this Entity requires Advance Payment for certain in-office and outpatient procedures. As a patient, I am required to be familiar with my Insurance coverage and its policies and know my co-pay, coinsurance, deductible, total out of pocket expense, effective date of coverage, pre-existing conditions AND whether I am receiving service from a contracted or out-of-network physician or other healthcare provider/facility. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge. **I have reviewed the above Policies & Agreements and hereby agree to comply with ENTITY Policies**

Signature: _____Date: _____

OUT OF NETWORK FINANCIAL POLICY

Peyton Berookim, MD, FACG appreciates your confidence and goodwill. You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan. If the patient's insurance rejects, denies or covers only a portion of treatment, the patient shall be responsible for immediate payment of the balance due. This payment may be requested and is due at the time of service. A pre-treatment deposit may be required.

Uninsured Patients:
All charges are due and payable at time of service. We accept cash and all major credit cards. We may reschedule your appointment if payment is not made prior to the services rendered.

Insured Patients:
We will bill your insurance company for your encounter as a courtesy to our patients if the patient provides the required insurance information.

No-Show, Re-scheduling and Cancellation Policy:
Appointments are in high demand and early cancellations will give other patients earlier access to timely care. Therefore, patients who fail to cancel their office appointment at least 48 hours in advance OR procedures at least 72 hours in advance will be charged a late cancellation fee of $85 for Office Visits and $400 for Endoscopic procedures. These fees will NOT be applied to any co-pay, deductible or coinsurance.

Delinquent / Unpaid Account:
Prior to providing services, payment of prior outstanding accounts will be requested and should be received.
Our office asks that you pay the balance of your account within 60 days of being billed by us.

Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency. A 40% Collection and / or Attorney Fee will be added to the principal balance and will be forwarded to a third-party collection agency for processing.

Refunds:
Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full.

Refund checks:
Checked returned for insufficient funds, closed accounts, stopped payment, or for any other reason will be subject to $50 fee.

I, the patient/patient's legal representative, understand and agree to abide by the financial policy set forth.

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Uses and Disclosures of your Protected Health Information not Requiring Your Consent.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Rights Regarding Your Protected Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to us. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read and understand the Notice of Privacy Practices. This notice described how Dr. Berookim and his staff may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected information.

Signature: _____ **Date:** _____

ON FILE CREDIT CARD AUTHORIZATION FORM

Our financial policy requires ALL patients to maintain a credit card/debit card on file with our practice. Our office submits your claim to your insurance and sends out monthly statements. If you have not paid your balance, the credit card/debit card will be used when you are more than 90 days overdue. Your card will also be charged fees as detailed in our **Financial Policy** (No-Show, Re-scheduling and Cancellation Policy).

Please complete the information below:

Patient Name: _____ Date of Birth: _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

*Please accompany this form with you credit card/debit card.

Signature: _____ **Date:** _____

I authorize Peyton Berookim M.D., Inc. to charge the credit card/debit card indicated in this authorization form according to the terms outlined above; the credit card provided will only be charged for a full balance, if/when my account has been delinquent more than 90 days. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.