GEORGE TAN MD, PLLC/dba: VEGAS DIGESTIVE HEALTH CENTER
5135 Camino Al Norte. Suite #150 | North Las Vegas, NV 89031
Phone: (702) 625-8989 | Fax: (702) 331-3115 WWW.VEGASDHC.COM

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name (Last, First MI): _____DOB: _____Age: _____

Social Security #: _____ Marital Status: _____ Gender: _____

Address (Street, City, State, Zip): _____

Home Phone #: _____ Cell phone #: _____ Work Phone #: _____

Email address: _____

Spouse's Name (Last, First MI): _____ DOB: _____

Spouse's Social Security #: _____ Spouse's Cell/Work Phone#: _____

Spouse's occupation: _____

Emergency contact: _____ Relation to patient: _____ Phone #: _____

Referring Physician: _____ Primary Physician: _____

Have you executed an Advanced Directive, Living Will, or a Durable Power of Attorney? _____

If yes, please provide us with a copy for your medical chart.

EMPLOYER INFORMATION

Employer Name: _____ Employer phone: _____ Occupation: _____

Employer address (Street, City, State, Zip): _____

INSURANCE INFORMATION

(If insured you must fill out this section in its entirety)

Primary Insurance: _____ Phone number: _____

Address (Street-City-State-Zip): _____

Name of Insured: _____ Soc Sec No._____ DOB_____

Policy # _____ Group #_____ Relationship to Patient_____

Secondary Insurance: _____ Phone number: _____

Address (Street-City-State-Zip): _____

Name of Insured: _____ Soc Sec No._____ DOB_____

Policy # _____ Group #_____ Relationship to Patient_____

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Privacy Practice Acknowledgement and Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security #: _____

By my signature below, I acknowledge that I have received a copy of the notice of Privacy Practices in my patient portal or a hard copy.

I authorize George Tan MD, PLLC/dba: Vegas Digestive Health Center to discuss and release my healthcare information to the following Person(s).

Name_____ Relationship_____Phone_____

Name_____ Relationship_____Phone_____

Name_____ Relationship_____Phone_____

I Further authorize the providers and staff of George Tan MD, PLLC/dba: Vegas Digestive Health Center to communicate and/or leave messages by

☐ Mail ☐ Email ☐ Phone, OK to leave message with detailed information
☐ Phone, OK to leave message with contact number only ☐DO NOT LEAVE MESSAGE

This request and authorization apply to:
☐ Healthcare information relating to the following treatment, condition, or dates:
☐All healthcare information
☐Other:
Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Please provide a date or event, if any, upon which this Authorization will expire. Please mark only one selection.
☐ No Expiration
☐ Date of Expiration _____/_____/_____
☐ Event: (Describe event upon which this Authorization will expire) _____

Patient Signature: _____Date Signed: _____

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MEDICATION HISTORY CONSENT

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare providers at George Tan MD, PLLC/dba Vegas Digestive Health Center to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Patient Name

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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FINANCIAL POLICY

Insurance Billing:

Your insurance policy is a contract between you and your insurance company. It is your responsibility to provide all accurate and current information regarding insurance(s) and be aware of the benefits and coverage of the insurance plan(s). It is your responsibility to know your benefits and how they would apply to your treatment plan. We will attempt to bill your insurance for all services that we provide; however, any account insurance allowable balance that is not paid by your insurance company will be your responsibility (or the guarantor listed on your insurance policy).

If our office is not contracted with your insurance carrier, it will be your responsibility to file your insurance claims directly with your insurance. If you do not notify our office about any change in your primary or secondary insurance information, you are fully responsible for any amount not paid by your insurance company.

Please be aware that some insurance plans require either a pre-authorization/certification and/or a written referral. It is your responsibility to understand the insurance plan requirements and ensure that the proper authorization is obtained at least three days prior to the date of service. If you fail to do so, this may result in denial by your insurance carrier and we will not be responsible for a disputed claim. Our office staff will contact your insurance plan to see if pre-authorization is required for your visit and procedure. Please note that pre-authorization is not a guarantee of payment as per your insurance company. Moreover, we will only attempt to obtain pre-authorization for your primary insurance only. For all services provided by our physician(s) in the hospital or surgery center, we will bill your health plan directly, but any balance due is your responsibility.

Copayment/Co-insurance/Deductible:

For patients with insurance all Co-payment, Coinsurance and/or Deductible are due at time of service without exceptions. Patients without insurance, all Payment is due at time services are rendered without exceptions.

Initials_____

Delinquent accounts can be subject to further collections by a third-party collection agency or attorney. Accounts will be considered delinquent if balance not paid after 90 days from the date of service. In the event your account is turned over to an outside collection agency, you will be responsible for any and all reasonable collection, interest, attorney's fees and court costs. The delinquent account will be listed with local and national credit bureaus.

Initials_____

Office Lab Tests:

If any cultures, blood or urine samples are taken at the office, please understand that you will receive a separate bill from the laboratory for the services.

Initials_____

Consent For Treatment:

I consent to having treatment, diagnostic, and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of George Tan MD, PLLC, dba Vegas Digestive Health Center. I authorize the release of any medical records or other information necessary to process my medical insurance claims for the purpose of TPO (Treatment, Payment, Operations). I also authorize payment of medical and/or governmental benefits to George Tan MD, PLLC/ dba Vegas Digestive Health Center for any and all services rendered. I further agree and understand that I have received the

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financial policy and will be responsible for all non-covered charges, Co-Payments, Deductibles and/or Co-insurances as designated by my insurance carrier(s).

Initials_____

OFFICE POLICIES

Phone Calls:

If you need to contact our office for any medical problems, questions, test results, scheduling, or any other issue related to your care, please leave your name (with the spelling of your last name), date of birth, phone number, and a detailed message. If you are calling for a medical issue, please leave a message for one of our medical assistants. Please be advised that our office has a high call volume, and that we will make every attempt to call you back in a timely fashion. Messages are checked throughout the day. If your call is received by 4:00pm, it will be returned within 24 business hours. Please do not leave multiple messages, as this only delays us in calling patients back. Thank you in advance for your patience.

Initials_____

Medication Refills:

Please allow 72 hours for prescription refills. Medication refills will only be done during regular business hours. No refills will be given after hours, during weekends or holidays. It is your responsibility to know when your prescription needs to be refilled. In addition, prescriptions called in on Friday's after 12pm will not be processed until the following business day (which is Monday, unless it is a holiday then Tuesday).

Initial_____

Pharmacy Information_____

Patient Portal:

Vegas Digestive Health Center uses our patient portal to communicate with patients in various ways (results, medication refills, general questions). Please note any emergency should not be communicated via the portal as it can take up to 2 business days to respond.

Initials_____

Results:

Results will be published onto your patient portal within 1-3 weeks. Please note results will not be given over the phone. If you wish to discuss your results with the physician an appointment must be made.

Initials_____

Late Appointments:

Any patient that arrives 20 minutes late to their appointment, is subject to their appointment being cancelled and rescheduled.

Initials_____

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No Show/Cancellation Policy:

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled office appointment. If you must cancel or reschedule a scheduled endoscopic procedure or diagnostic test, we require that you call at least three working days (72 business hours) in advance. Appointments and procedure times are in high demand, and early cancellation will give another person the possibility to have access to timely care. Patients failing to cancel or reschedule their office appointment as indicated above (at least 24 hours in advance) will be billed a cancellation fee of $50 if an initial consult and $25 for a follow-up visit. Patients failing to cancel or reschedule their scheduled procedure or diagnostic test as indicated above (at least 72 business hours in advance; if your procedure or diagnostic test is on a Monday, you must give notice of cancellation to our office by Wednesday at 5:00 P.M.) will be billed a cancellation fee of $150. All fees must be paid in full prior to the scheduling of future appointments.

All returned checks are subject to a $25.00 return check fee.

Initials_____

Multiple Appointment Cancellations or Multiple Re-Scheduled Appointments

For patients who have had multiple appointment cancellations or multiple re-scheduled appointments may result in termination from our practice.

Initials_____

Phone Consultations:

After-hour phone calls are limited to urgent medical issues. All other medical matters (including test results) must be discussed in the office. It is the patient's responsibility to follow-up for any results. Calling the doctor after hours or requesting phone consultation will sometimes result in a charge which insurances may not pay--making you responsible if your insurance does not cover telemedicine service provided by our practice. Charges vary depending on length of phone conversation: 1-15 minutes--$50.00, 16-30 minutes--$75.00. If you have not been seen in our office for over a year and have urgent medical issues, you need to go to the emergency room for care.

Administrative Fees:

All medical record requests are subject to a preparation fee. Please allow 5-7 business days to complete the request. A fee of $100 will be collected for completing and returning administrative forms and tasks (i.e. FMLA, disability, peer review with your insurance etc).

Treatment of Staff:

Any patient who acts in any way disruptive or abusive towards our staff can be discharged from the practice.

Initials_____

Acknowledgment and Authorization:

I have read, understand and agree to abide by the above Office and Financial Policy

Signature: _____ Date: _____

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PATIENT MEDICAL INFORMATION

Patient Name (Last, First MI): _____

Reason For Visit: _____

Have you seen another gastroenterologist or have you presented to a hospital recently for this problem? ☐ Yes ☐ No

If yes, which hospital/doctor did you see? _____

Past or Present Medical Conditions.
Please check if you have a history of any of the following illnesses and when diagnosed:

☐ NONE
☐ Anxiety
☐ Asthma
☐ Arthritis
☐ Alcoholism
☐ Anemia
☐ Auto immune disorder
☐ Barrett's esophagus
☐ Bipolar disorder
☐ Bleeding disorder
☐ Bowel obstruction
☐ Celiac disease
☐ Chest pain
☐ Cirrhosis
☐ Colon cancer
☐ Colon polyps
☐ Colitis
☐ Congenital heart disease
☐ Congestive heart failure
☐ COPD
☐ Crohns disease
☐ Depression
☐ Diabetes
☐ Dialysis
☐ Diverticulosis/Diverticulitis
☐ Esophagus cancer
☐ Fatty liver
☐ Gallstones
☐ Gastrointestinal bleeding
☐ Heart attack
☐ Heartburn
☐ Heart rhythm disturbance
☐ Hemochromatosis
☐ Hemorrhoids
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Heart valve replacement
☐ High blood pressure
☐ H pylori infection
☐ HIV/AIDS
☐ Irritable bowel syndrome
☐ Jaundice
☐ Kidney disease
☐ Kidney stones
☐ Leukemia/Lymphoma
☐ Liver cyst
☐ Liver cancer
☐ Migraine
☐ Menstrual problems
☐ Pancreatitis
☐ Pancreatic cancer
☐ Scleroderma
☐ Seizures
☐ Sleep Apnea
☐ Stomach polyps
☐ Stomach cancer
☐ Stroke/TIAs
☐ Thyroid problems
☐ Trouble Swallowing
☐ Tuberculosis
☐ Ulcerative Colitis
☐ Ulcers (stomach or duodenal)

Other: _____

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Past Surgeries or Procedures:
Please check if you have had any of the following procedures and date (month/year):

☐NONE ☐ Endoscopy _____ ☐ Colonoscopy _____

☐ Appendectomy _____
☐ Cesarean section (C-section) _____
☐ Colon resection _____
☐ Gallbladder surgery _____
☐ Gastric bypass _____
☐Gastric sleeve _____
☐ Heart stents _____
☐ Hernia repair _____
☐ Hemorrhoidectomy _____
☐ Hysterectomy _____
☐ Nissen Fundoplication _____
☐ Stomach Feeding Tube _____

Other: _____

Adverse Reactions to Anesthesia: ☐ Yes ☐ No

If Yes, please explain:_____

Family History: Please check all diseases that apply and which family member was affected.

☐ Crohn's disease _____
☐ Colon cancer _____
☐ Colon polyps _____
☐ Esophagus cancer _____
☐ Liver disease _____
☐ Liver cancer _____
☐ Pancreatic cancer _____
☐ Stomach cancer _____

Other: _____

Social History: For each category, if answer is yes, please specify the amount, frequency, duration of use or quit date

Tobacco: ☐ Yes ☐ No

_____

Alcohol: ☐ Yes ☐ No

_____

Recreational Drug use: ☐ Yes ☐ No

_____

Medications:

Do you currently take any blood thinners or antiplatelet agents? (eg aspirin, clopidogrel/Plavix, warfarin/Coumadin, ticagrelor/Brilinta, apixaban/Eliquis, rivaroxaban/Xarelto, dabigatran/Pradaxa, prasugrel/Efficient, edoxaban/Savaysa, dalteparin/Fragmin, enoxaparin/Lovenox, Heparin, etc):

☐ Yes ☐ No

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If yes, please list the **name, dose, frequency** and reason for taking blood thinners here:

_____

Please list all of your other **Current Medications** including supplements and over the counter meds (**Name, Dose, Frequency**).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Other: _____

Medication Allergies

☐ No Known Drug Allergies

☐ Aspirin
☐ Codeine
☐ Iodine
☐ Other: _____
☐ Latex
☐ Sulfa
☐Penicillin

Gastrointestinal Review of Symptoms: For each category, if the answer is yes, please ***specify for how long*** you have had your symptoms.

Abdominal Pain: ☐ Yes ☐ No _____

☐ Intermittent
☐ Constant
☐ Burning
☐ Sharp
☐ Cramping
☐ Dull ache
☐ Better with food
☐ Not better with food
☐ No relationship with food
☐ Better after bowel movement

Severity: 1 (mild) – 10 (severe)? _____
What makes the pain better? _____
What makes the pain worse? _____
Have you tried any medication for your pain? _____

Abdominal swelling or bloating (specify): ☐ Yes ☐ No _____

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Acid Reflux/Heartburn: ☐ Yes ☐ No _____

Altered mental status or confusion: ☐ Yes ☐ No _____

Change in bowel habits: ☐ Yes ☐ No _____

Constipation: ☐ Yes ☐ No _____

Diarrhea: ☐ Yes ☐ No _____

Fecal incontinence: ☐ Yes ☐ No _____

Fever or chills: ☐ Yes ☐ No _____

Jaundice/Yellowing of the skin: ☐ Yes ☐ No _____

Nausea: ☐ Yes ☐ No _____

Trouble swallowing: ☐Yes ☐ No _____

☐ Solids ☐ Liquids ☐ Both

Rectal bleeding: ☐ Yes ☐ No _____

☐ Bright red blood ☐ Black, tarry stool

Rectal pain: ☐ Yes ☐ No _____

Unintentional weight loss: ☐ Yes ☐ No _____

Vomiting: ☐ Yes ☐ No _____

Other:

_____

_____

_____