Patient Registration

(Please Print)

Name____ Date of Birth_____/_____/______ Age________
(Last) (First) (MI)

Mailing Address____

City___________________________ State_______________ Zip______________

Social Security Number _______-______-________ Marital Status ___________________ Sex: Male / Female

Spouse's Name _____________________________ Date of Birth____/____/______Social Security_____-_____-________
(Last) (First) (MI) **(if covered under spouse's INS)**

Primary Phone # (______) _______-_________ Alternate (Secondary) Phone # (______) _______-_________

Employer ______________________ Primary Doctor________________________________ ◯ No Primary Doctor

Race:

- ◯ American Indian/Alaska Native
- ◯ Asian
- ◯ Black/African American
- ◯ White/Caucasian
- ◯ Native Hawaiian
- ◯ Other Pacific Islander
- ◯ Other __________________________

Ethnicity:

- ◯ Not Hispanic / Not Latino
- ◯ Hispanic or Latino

Language Preferred: _________________________________

Pharmacy Name: ________________________ City____________________________ Street _________________________

In case of emergency, who should be notified?

Name________________________________ Relationship___________________ Phone # (______) _______-________

May we disclose/discuss personal medical information with this person? Yes or No

I the undersigned have insurance coverage with _______________________________________(Name of Insurance Co) and assign directly to **Hillsboro Gastroenterology, PC** and **Jeremy M. Lake, M.D. LLC** and **Barry A. Ross, M.D.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

X____ Date ______________________________

Name: ______________________________ **DOB:** ______________ **Today's Date:** _________________

Reason for visit / Main complaint:

____

Medication(s) (Drugs, Pills, Vitamins and Supplements):

1. ______________________ 6. __________________________ 11.__________________________
2. ______________________ 7. __________________________ 12. __________________________
3. ______________________ 8. __________________________ 13. __________________________
4. ______________________ 9. __________________________ 14. __________________________
5. ______________________ 10. __________________________ 15. __________________________

Medicine Allergies:

Surgeries / Dates:

Social History:

Do you drink alcohol? _____ Drinks per day? ____
Drinks per week? _____ per month? _____
Do you smoke? _____ Packs daily? ____ Years? ____
Do you use illicit drugs? ______
If yes, what kind? ______________________
Current Occupation/Employer: ___________________
What kind of work? ___________________
Marital Status: □ Single □ Divorced □ Married □ Widowed
Who lives with you? ___________________________

Family History:

	Mother	Father	Sister	Brother
Asthma	□	□	□	□
Cancer	□	□	□	□
Colon Polyps	□	□	□	□
Colon Cancer	□	□	□	□
Heart Disease	□	□	□	□
Diabetes	□	□	□	□
Stroke	□	□	□	□
	Grandma (Maternal)	Grandma (Paternal)	Grandpa (Maternal)	Grandpa (Paternal)
Asthma	□	□	□	□
Cancer	□	□	□	□
Colon Polyps	□	□	□	□
Colon Cancer	□	□	□	□
Heart Disease	□	□	□	□
Diabetes	□	□	□	□
Stroke	□	□	□	□

Indicate if you are having any current problems, signs or symptoms in any of the following areas:

□ General Wellness □ Eyes □ Skin □ Other
□ Ears, Nose, Throat □ Stomach /Digestion □ Lungs/Breathing
□ Heart /Circulation □ Diarrhea /Constipation □ Neurological
□ Allergies □ Reproductive/Urinary □ Thyroid/Endocrine
□ Psychiatric □ Blood/Lymph □ Muscles/Joints/Bones

Physician Comments-ROS
□ *All other systems negative*

Review of Systems

Name: _______________________________ Date of Birth: _____/_____/______ Today's Date: ___________

Indicate if you are having any current problems, signs or symptoms in any of the following areas:

General Wellness

□ Fever □ Chills □ Fatigue
□ Weight Gain □ Weight Loss

Eyes

□ Recent Vision Problem □ Double Vision □ Dry Eyes

Ears / Nose / Throat

□ Decreased Hearing □ Hoarse Voice □ Sore Throat
□ Nasal Congestion □ Vertigo
□ Hearing Aid: Left / Right/ Bilateral / Other

Lungs / Breathing

□ Shortness of Breath □ Cough □ Wheezing
□ Sleep Apnea: CPAP / BiPAP

Heart / Circulation

□ Chest Pain □ Palpitations □ Leg Swelling

Diarrhea / Constipation

□ Nausea □ Vomiting □ Diarrhea
□ Constipation □ Heartburn □ Abdominal Pain
□ Loss of Appetite □ Rectal Pain □ Bloating
□ Change in Stool Color □ Change in Stool Consistency

Urinary / Reproductive

□ Blood in Urine □ Change in Urine Stream □ Urinary Frequency
□ Urinary Hesitancy □ Urinary Incontinence □ Irregular Menses

Blood / Lymph

□ Anemia □ Bruising Tendency □ Bleeding Tendency

Thyroid / Endocrine

□ Cold Intolerance □ Heat Intolerance □ Excessive Hunger
□ Hot Flashes

Muscles / Joints / Bones

□ Back Pain □ Neck Pain □ Joint Pain
□ Joint Stiffness □ Restless Leg

Skin

□ Rash □ Skin Lesion

Neurological

□ Numbness □ Tingling □ Headache
□ Memory Loss □ Seizures □ Tremor
□ Weakness

Psychiatric

□ Anxiety □ Depression □ Hallucinations
□ Memory Difficulties □ Sleeping Problems
□ Eating Disorder: Anorexia / Laxative Abuse / Binging / Induced Vomiting / Excessive Exercise

Physician Comments-ROS

Gastroenterology
232 SE 7th Ave., Hillsboro, OR 97123
(503)640-1614

Randy D. Watson, M.D. Curtis J. Larson, M.D.
Jeremy M. Lake, M.D. Barry A. Ross, M.D.

Screening Colonoscopy

Our office may be asked to schedule you for a screening colonoscopy. Patients who have screening examinations have no signs or symptoms and may have a set benefit for diagnostic procedures with their insurance company

You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance company may pay differently on your claim. You may be responsible for the deductible and/or co-payment. Please contact your insurance company if you have questions regarding your coverage.

I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay, and any out-of-pocket expenses in the event that my scheduled screening examination results in a procedure during which polyps or other abnormalities are found.

______________________________ ______________________________
Patient Name Signature

______________________________ ________________
Witness Signature Date

Gastroenterology

232 SE 7th Ave., Hillsboro, OR 97123
(503)640-1614

Randy D. Watson, M.D. Curtis J. Larson, M.D.
Jeremy M. Lake, M.D. Barry A. Ross, M.D.

CONSENT to OBTAIN and/or RELEASE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, ___________________________________, hereby authorize the office to use, obtain and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I authorize the office to obtain information from my pharmacy regarding my medications and/or medication history. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians may refuse to treat me.

I have been informed that the office has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care 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 the office in writing, but if I revoke my consent, such revocation will not affect any actions that the physicians took before receiving my revocation.

I understand that the office has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that the office restricts how my individually identifiable health information is used, obtained and/or disclosed to carry out treatment, payment, or health operations. I understand that the physicians do not have to agree to such restrictions, but that once such restrictions are agreed to, the office must adhere to such restrictions.

____ ___________________________
Signature of patient or patient's representative Date

____
Relationship to patient

Gastroenterology
232 SE 7th Avenue, Hillsboro, OR 97123
(503)640-1614

Randy D. Watson, M.D.
Curtis J. Larson, M.D.
Jeremy M. Lake, M.D. LLC
Barry A. Ross, M.D.

FINANCIAL POLICY

PATIENT REFERRALS

Many HMO plans and other insurance companies require referrals from your primary physician prior to our treating you. **IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL**. Please bring it to our attention if you need to have a referral. If you fail to bring this to our attention and treatment is administered without a referral from your primary physician, you will be responsible for the cost of that treatment should your insurance company deny the claim.

NO INSURANCE

If you do not have health insurance coverage, we ask that you make a $200.00 deposit today. For any procedures that will need to be scheduled, there will be a $400.00 deposit required at time of scheduling. Payment arrangements can be made for the balance.

INSURANCE BILLING

We will bill your primary and secondary insurance. You are responsible for the payment of your account regardless of the status of your insurance. Co-payments are due at the time of service. It is your responsibility to notify this office of any changes in your insurance carrier or coverage.

MEDICARE

Medicare will not pay your charges in full. We do accept Medicare assignment and will write off a portion of our bill as directed by Medicare when they make a payment. The remaining balance is billed to a secondary insurance or to you the patient.

PAYMENT ARRANGEMENTS

Payment arrangements are available. You may contact the billing department to set up a payment plan. Accounts 90 days past due will have a fee of $25.00 a month and may be referred for collection. **There will be a $25.00 fee for returned checks.**

APPOINTMENT CANCELLATIONS

If you are unable to keep a scheduled office appointment, please phone our office prior to 24 hours of your appointment time. If you are unable to keep a scheduled procedure appointment, please call our office prior to 48 hours of your appointment time. **There will be a $50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice. There will be a $200.00 charge for all no-show and/or appointment cancellations for scheduled procedures at Tuality Community Hospital with less than 48 hours notice**. *Please note that we place appointment reminder calls as a courtesy, if you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.*

I, ____, Date of Birth: ______/_______/_______,
(Print Name)

HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

Signature____ Date: ____________________________

Effective as of 07/01/2011