Advanced Gastroenterology & Hepatology Associates
7055 N. Maple Ave. #106 • Fresno, CA 93720
Ph. (559) 297-2259 • Fax (559) 297-2269

FC: _____

PCP: _____

HCL: _____

Patient Information

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE HOME PHONE: _____

SOCIAL SECURITY #: _____ WORK: _____ PHONE CELL: _____

Email Address: _____

REFERRING DOCTOR: _____ TELEPHONE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO SUBSCRIBER: _____

PATIENT'S EMPLOYER NAME: _____ TELEPHONE: _____

SPOUSE'S NAME: _____

I AUTHORIZE ADVANCED GASTROENTEROLOGY & HEPATOLOGY ASSOICATES TO DISCUSS MEDICAL INFORMATION RELATED TO MY CARE WITH THE FOLLOWING FAMILY MEMBERS/INDIVIDUALS.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY INFORMATION

(GUARANTOR)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE: _____ OCCUPATION: _____

SUBSCRIBER'S EMPLOYER NAME: _____

ADDRESS: _____

SUBSCRIBER SS #: _____

PATIENT'S RELATIONSHIP TO GUARANTOR: 01 ☐ SAME 02 ☐ HUSBAND 03 ☐ WIFE 04 ☐ SON 05 ☐ DAUGHTER 06 ☐ STEPCHILD

OTHER: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?: _____

DISCLOSURE: Dr. Jayanta Choudhury, Dr. Muhammad Sheikh and Dr. Mandeep Singh have a financial interest at the Herndon Surgery Center.

INSURANCE CLAUSE: I understand that if this or any other visit precedes the effective date of my insurance; or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visit.

FINANCIAL DISCLOSURE: Advanced Gastroenterology & Hepatology Associates is a member of Community Foundation Medical Group (CFMG) and I may receive a bill from CFMG for services provided by Advanced Gastroenterology and/or the group's providers.

TREATMENT CONSENT: I hereby give consent for medical or surgical treatment to: Dr. Jayanta Choudhury, Dr. Muhammad and Dr. Mandeep Singh Associates to care for self or I am duly authorized by the patient as his/her general agent to give consent for such treatment.

ASSIGNMENT OF PAYMENT OF BENEFITS: I hereby authorize payment directly to Choudhury, Sheikh & Singh Inc. of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

RELEASE OF INFORMATION: I hereby give consent to release to authorized persons of financial and medical information concerning care and treatment and changes therefore as may be required to complete all claims for benefits.

_____ _____

Pt. Signature / Pt. Representative Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I may ask for a copy of this or any amended Notice of Privacy practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- □ Parent or guardian of minor patient
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Cancellation Policy

Effective May 1, 2022

As a courtesy to other patients, please notify us if you are unable to keep your appointment.

You may be charged a cancellation fee of $100.00 if you fail to cancel within 1 week of a procedure related appointment, and $50.00 for an office appointment. Your insurance may not cover this fee.

Signed: _____ Date: _____

Race: Asian/A Asian Pacific/F African-American/B Caucasian/C
Hispanic/H Alaskan/I Native American/G Other/E

Ethnicity: Latino/Hispanic/L Other/O Not Reported/Refused/N

Language: _____

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Patient Name: _____
DOB: _____
Patient #: _____

Past Medical/Surgical/Social History

Past Medical History. Please check all previous illnesses or conditions below.

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Back problem
- ❑ Barrett's Esophagus
- ❑ Cardiac Disease
- ❑ Celiac disease
- ❑ CHF
- ❑ Cirrhosis
- ❑ Colon polyps
- ❑ COPD
- ❑ Diabetes mellitus
- ❑ Diverticulosis
- ❑ Heartburn
- ❑ Hemophilia or bleeding disorder
- ❑ Hepatitis
- ❑ Hypercholesterolemia
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Immune deficiency
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Myocardial infarction
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Prostate disease
- ❑ Sleep apnea
- ❑ Stroke
- ❑ TIA
- ❑ Other: _____

Surgical History. Please check any surgeries you have had and indicate date if known.

- ❑ Appendectomy
- ❑ Bariatric surgery
- ❑ Bladder repair
- ❑ Breast surgery
- ❑ C-Section
- ❑ Colon surgery
- ❑ Colonoscopy
- ❑ Cosmetic surgery
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Gallbladder surgery
- ❑ Heart surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint replacement
- ❑ Ovary removal
- ❑ Pancreas surgery
- ❑ Prostate surgery
- ❑ Small intestine surgery
- ❑ Spine surgery
- ❑ Take Down Colostomy
- ❑ Tonsillectomy
- ❑ Tubal ligation
- ❑ Upper GI endoscopy
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Other: _____

Social History

Do you smoke? ❑ No ❑ Yes If yes, how many packs a day?_____
Do you drink alcohol? ❑ No ❑ Yes If yes, how much per week?_____
Do you use smokeless tobacco? ❑ No ❑ Yes If yes, how much per week?_____
Have you ever used intravenous drugs? ❑ No ❑ Yes
Do you have tattoos? ❑ No ❑ Yes

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A Member of Community Foundation Medical Group & Part of Santé Health Foundation

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Allergies & Medications

Please list the following:

Allergies to Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Prescriptions:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Over the counter medications/Vitamins:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____

Address/Cross Street: _____