* BASIM ABDELKARIM, M.D.
* IAN DONAHUE P.A.
*BRIANNE BRIDGELAND NP
*PRIYANKA YARAMADA, M.D.
*MIGUEL CERVANTES LOPEZ PA-C

1310 SAN BERNARDINO ROAD SUITE 103 UPLAND, CALIFORNIA 91786 P) 909-920-0444 F) 909-920-5044

10807 LAUREL ST STE 200 RANCHO CUCAMONGA CA 91730 P) 909-920-0444 F) 909-920-5044

NEW PATIENT INTAKE FORMS

GENERAL INFORMATION

PATIENT NAME_____ BIRTH DATE_____/_____/_____ AGE_____
(LAST) (FIRST) (M.I.)

ADDRESS_____ CITY/STATE_____ ZIP_____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

EMAIL ADDRESS_____

SEX: □ FEMALE □ MALE RACE_____ SSN_____

EMERGENCY CONTACT_____ RELATIONSHIP_____ # (_____) _____-_____

PRIMARY CARE PHYSICIAN_____ CITY_____ # (_____) _____-_____

PHARMACY INFORMATION

PHARMACY NAME_____ PHARMACY PHONE # (_____) _____-_____

ADDRESS_____ CITY/STATE_____ ZIP_____

GASTROENTEROLOGY INFORMATION

REASON FOR TODAY'S VISIT: □ COLONOSCOPY SCREENING □ ENDOSCOPY (EGD) SCREENING
□ OTHER_____

HAVE YOU PREVIOUSLY HAD A COLONOSCOPY? □ YES □ NO
IF YES: DATE_____ HOSPITAL/CITY_____ PERFORMED BY_____

REASON_____ FINDINGS_____

HAVE YOU PREVIOUSLY HAD AN ENDOSCOPY (EGD)? □ YES □ NO
IF YES: DATE_____ HOSPITAL/CITY_____ PERFORMED BY_____

REASON_____ FINDINGS_____

CURRENT MEDICATIONS

□ NONE □ UNKNOWN

NAME	STRENGTH	DOSE	FREQUENCY	HOW LONG HAVE YOU BEEN TAKING THIS MEDICATION
EXAMPLE: OMEPRAZOLE	**EXAMPLE:** 20 mg.	**EXAMPLE:** 1 TABLET	**EXAMPLE:** ONCE PER DAY	**EXAMPLE:** 6 MONTHS

MEDICATION ALLERGIES

□ NO KNOWN MEDICATION ALLERGIES (NKDA)

MEDICATION	REACTION

SURGICAL HISTORY

PROCEDURE	YEAR

SOCIAL HISTORY

ALCOHOL: □ CURRENT □ PAST □ NEVER
TOBACCO: □ CURRENT □ PAST □ NEVER
SUBSTANCE ABUSE: □ CURRENT □ PAST □ NEVER
EMPLOYED: □ NO □ YES IF YES, WHAT IS YOUR OCCUPATION_____
MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ SEPARATED □ WIDOWED □ LIFE PARTNER
EXERCISE: □ NEVER □ 1-2 TIMES/WEEK □ 3-4 TIMES/WEEK □ 5-6 TIMES/WEEK □ DAILY
SEXUALLY ACTIVE: □ NO □ YES IF YES, TYPE OF CONTRACEPTIVE USED_____

FAMILY MEDICAL HISTORY

	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER (MATERNAL)	GRANDMOTHER (PATERNAL)	GRANDFATHER (MATERNAL)	GRANDFATHER (PATERNAL)
EXAMPLE: COLON CANCER		X		X	X			
ALCOHOLISM								
COLITIS								
COLON CANCER								
COLON POLYPS								
CROHN'S DISEASE								
DIABETES								
HEART DISEASE								
HEPATITIS								
HIGH BLOOD PRESSURE								
LIVER DISEASE								
STOMACH CANCER								
STROKE								
ULCER DISEASE								
ULCERATIVE COLITIS								
OTHER:								

CURRENT SYMPTOMS

*** ONLY CHECK BOXES OF SYMPTOMS/DISEASES THAT YOU ARE CURRENTLY EXPERIENCING:**

Gastroenterology:

□ Abdominal pain	□ Change in bowel habits	□ Hemorrhoids
□ Acid reflux	□ Colon polyps	□ Hepatitis
□ Anal itching	□ Constipation	□ Hernia
□ Anal pain	□ Diarrhea	□ Jaundice
□ Anal swelling	□ Difficulty swallowing	□ Loss of appetite
□ Belching	□ Diverticulitis	□ Nausea
□ Black/tarry stool	□ Diverticulosis	□ Ulcer(s)
□ Bloating	□ Gallbladder issues	□ Vomiting
□ Blood in stool	□ Heartburn	

Endocrinology:

□ Diabetes	□ Thyroid disease	□ Recent weight gain / loss

Ears, Eyes, Nose, Throat:

□ Double/blurred vision	□ Frequent sore throat	□ Hoarseness	□ Sinus Trouble

Heart/Lungs:

□ Asthma	□ Emphysema	□ Shortness of breath
□ Bronchitis	□ Heart murmur	□ Sleep apnea
□ Chest pain	□ Palpitations	□ Swelling of hands
□ Cough	□ Pneumonia	□ Swelling of feet
		□ Tuberculosis

Neurology:

□ Dizziness	□ Numbness	□ Tremors
□ Headache	□ Seizures	□ Weakness of arms/legs
□ Migraines	□ Tingling	

Musculoskeletal:

□ Arthritis	□ Gout	□ Osteoporosis

Skin:

□ Eczema	□ Psoriasis	□ Rashes

Hematology/Oncology:

□ Anemia	□ Bruise easily	□ Cancer / Type:

Urinary:

□ Bladder infection	□ Kidney infection	□ Painful urination
□ Blood in urine	□ Kidney stones	□ STD / Type:

Female Only:

□ Irregular period	Last menstrual period date:

Other:

□ Anxiety	□ Depression	□ Difficulty sleeping
□ Memory loss	□ Nervousness	□ Stress

I voluntarily consent to authorize my healthcare provider Dr. Basim Abdelkarim, Dr. Priyanka Yaramada, and Ian Donahue P.A. to use or disclose my health information during the term of this authorization to the recipient(s) that I have identified below:

Name_____ Relationship_____ # (_____) _____-_____

Name_____ Relationship_____ # (_____) _____-_____

Name_____ Relationship_____ # (_____) _____-_____

Name_____ Relationship_____ # (_____) _____-_____

_____ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

_____ Only the following records or types of health information,

_____

_____

_____

I understand that this authorization will remain in effect until I provide a written notice of cancellation to Dr. Basim Abdelkarim, Dr. Priyanka Yaramad, Ian Donahue P.A. and Brianne Bridgeland N.P.

Patient Name_____

Patient
Signature_____

Date_____/_____/_____

NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to provide you, the patient, a Notice of our Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

I understand that I may request in writing that you restrict how my private information is used: to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree, then you are bound to abide by such restrictions.

I hereby acknowledge that I was given a copy of BASIM Z. ABDELKARIM INC.'S Notice of privacy practices to read. I was also given the opportunity to have a copy to take with me if I desired.

Patient Name_____

Patient Signature_____ Date_____/_____/_____

CO-PAYMENTS

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards (EXCEPT AMEX). Absolutely no post-dated checks will be accepted.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

APPOINTMENTS/PROCEDURES

We reserve the right to charge $50 for office visits that are a "NO SHOW" or if the appointment is canceled less than 48 hours in advance. **We also reserve the right to charge $100 for procedures (COLO/EGD) that are a "NO SHOW", canceled less than 48 hours in advance or directions not followed.** We have these policies in place because when you schedule an appointment or procedure you are taking that appointment slot on the schedule. We also "NO SHOW" patients after 15 minutes of their scheduled appointment time because we do book appointments consecutively so when patients are over 15 minutes late to their scheduled appointment it puts the providers and the other patients behind schedule.

REFERRALS AND PRIOR AUTHORIZATIONS

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or prior authorization, you are responsible for obtaining it. Failure to obtain the referral and/or prior authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I also authorize the release of all medical and insurance related information to the Health Care Financing Administration, its agents, and/or any other insurance carriers, as needed to determine benefits or process claims for the physicians in this office. I permit a copy of this authorization to be used, as needed, in place of the original, and I request payment of Medicare and/or other medical insurance benefits be made to, BASIM Z. ABDELKARIM M.D., INC. on my behalf for services rendered.

I am responsible for all financial obligations of health services for the above patient.

Patient Name: _____

Signature: _____ Date_____/_____/_____

Refusal to sign the above consent will result in our facility unable to render medical treatment/care.