

# Desert Gastroenterology Consultants

The office of:

Dr. Gary M. Annunziata  
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35900 Bob Hope Drive, Ste. 275  
Rancho Mirage, CA. 92270  
Telephone- (760) 321-2500  
Fax- (760) 321-5720

The office is located on Bob Hope Drive between Gerald Ford and Dinah Shore  
in the Rancho Mirage Professional Plaza.

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Patient Name- \_\_\_\_\_

Appointment Date- \_\_\_\_\_

Appointment Check-in Time- \_\_\_\_\_

Appointment Time- \_\_\_\_\_

**Welcome to our office!!**

Enclosed you will find our new patient paperwork. We hope you find your experience with our office a pleasant one. Enclosed you will find the following forms that need to be completed PRIOR TO your scheduled appointment.

1. Patient information sheet (please fill out completely)
2. Health History Questionnaire (4pages front and back total of 8)
3. Patient Medication List (fill out completely, dosage and directions)
4. Office Policy (2pages front and back and one single page total of 5pgs.)
5. Other- \_\_\_\_\_

Please fill out these forms completely and mail or fax to (760) 321-5720 or bring them to our office PRIOR to your appointment.

In addition, please bring in your insurance cards and a photo ID. Please double check your insurance card(s) and make sure your member ID and the claims mailing address are legible, if not please contact your insurance carrier for the correct information.

We appreciate your cooperation. If you have any questions, please contact our office.

Sincerely,  
Desert Gastroenterology Consultants

Website:

If you would like additional information about our office, we would ask that you visit our website at: [www.desertgastro.net](http://www.desertgastro.net)

# DESERT GASTROENTEROLOGY CONSULTANTS

GARY M. ANNUNZIATA, D.O. / ANH T. DUONG, M.D. / JONATHAN C. LIN, M.D. / NATALIE SLOAN, FNP

## PATIENT INFORMATION

### GOVERNMENT REQUIREMENT FOR ELECTRONIC HEALTH CARE REPORTING

PREFERRED LANGUAGE:  ENGLISH  SPANISH  OTHER \_\_\_\_\_

RACE:  WHITE  AFRICAN AMERICAN  AMERICAN INDIAN OR ALASKA NATIVE  
 NATIVE HAWAIIAN OR PACIFIC ISLANDER  DECLINE

ETHNICITY:  HISPANIC/LATINO  NON-HISPANIC/LATINO  DECLINE

### PATIENT

NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
FIRST MIDDLE LAST

### PERSON LEGALLY RESPONSIBLE

(IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN) \_\_\_\_\_

### PERMANENT

MAILING ADDRESS : \_\_\_\_\_  
STREET CITY ZIP HOME PHONE

LOCAL ADDRESS: \_\_\_\_\_  
(IF DIFFERENT FROM ABOVE) STREET CITY ZIP CELL PHONE

SOCIAL SECURITY NO.: \_\_\_\_\_ DRIVERS LICENSE NO.: \_\_\_\_\_

STATUS:  SINGLE  MARRIED  DIVORCED  WIDOW(ER)  DOMESTIC PARTNER

PATIENTS EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_  
STREET CITY ZIP WORK PHONE

## EMERGENCY CONTACT

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INS. \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

SECONDARY INS. \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_

## PHYSICIAN INFORMATION

REFERRING PHYSICIAN \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

SIGNATURE \_\_\_\_\_

# OUR OFFICE POLICY

In response to the complex healthcare industry, we have taken steps to optimize our operations to spend more time on patient care and less time on administration. This will require your help. Please carefully read the items below as they will be strictly enforced. Our goal is to provide high quality, compassionate and timely healthcare.

1. Our office practices a Physician-Patient Arbitration Agreement. To be a patient in this practice, the arbitration contract must be signed.
2. *Know your insurance plan and what your benefits are.* Many visits may not be covered. It is your responsibility to understand your insurance coverage and benefits. If we are not contracted provider with your insurance plan you will incur higher out-of-pocket expenses.
3. Co-payments, Deductibles, and Co-Insurance are due at the time of service.
4. There is an additional charge for all forms, medical records and administrative requests.
5. There will be a \$25.00 charge on all returned checks.
6. All pharmacy refill requests should be done by you calling your pharmacy and asking them to fax our office a refill notice. There will be no weekend refills.
7. You must update us with new address, telephone numbers and insurance as soon as possible.
8. We realize that your appointment may be several weeks after your test is complete. We ask that you call our office if you would like to know the results of any tests prior to your next office visit. The purpose of your follow up office visit is to review the results of a test, pending records, or to follow up on a chronic or unresolved problem. Failure to comply with this may result in delay of diagnosis, treatment prolonged illness or death.
9. Due to the volume of tests, we are unable to call results to every patient. If you would like to know your results or are unable to be at your appointment, IT IS YOUR RESPONSIBILITY to call the office. We ask that you never assume that your tests are negative if the office has not called you.
10. Please understand our office policy of NOT allowing an established patient to switch to another physician within this practice.
11. If you are advised to go to the Emergency Room by a physician or representative you must do so. Failure to comply may result in delay of diagnosis, treatment, prolonged illness, or death
12. I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also hereby authorize the physician to release any information required to my insurance in order to process this or any future medical claims with this office.

I have read and agreed to follow the above-mentioned guidelines and by signing below I acknowledge receiving a copy of this.

\_\_\_\_\_  
Patient Name- Please Print

\_\_\_\_\_  
Patient/or Guardian Signature

\_\_\_\_\_  
Date

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Patient Name-\_\_\_\_\_ Date of Birth-\_\_\_\_\_

Please complete the following medication and drug allergy form. Include medication name, strength, and how often you take it. If you require additional space, please use a separate sheet of paper or write on the back of this form.

MEDICATION NAME:	STRENGTH:	HOW MANY TIMES A DAY:

**ALLERGIES** (Please include medication name and type of allergic reaction you experience):

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**HEALTH HISTORY**

**GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D.  
JONATHAN C. LIN, M.D., MPH / NATALIE SLOAN, FNP.**

**PATIENT NAME-** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

*To help us meet all your needs, please fill out both sides of this form completely in ink. This is a confidential record of all your medical history and will be kept in this office.*

*Today's Date-* \_\_\_\_\_

*Place of Birth-* \_\_\_\_\_

*Highest level in School-* \_\_\_\_\_

*Primary Care Physician-* \_\_\_\_\_

*Occupation-* \_\_\_\_\_

**Reason for appointment today/Chief Complaint**

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**Hospitalization or Surgery—Please indicate date and reason**

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**Habits**

*Smoking (amount per week)* \_\_\_\_\_

*If former smoker, date quit* \_\_\_\_\_

*Alcohol (type & amount per week)* \_\_\_\_\_

*Caffeine (type & amount per day)* \_\_\_\_\_

*Street Drugs (type & amount per day)* \_\_\_\_\_

**Family History- please fill in as much information as possible- please check box if diagnosis applies:**

Diagnosis	Father Age at death_____ Cause of Death: _____	Mother Age at Death_____ Cause of death: _____	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
Hypertension						
Stroke						
Cancer (type): _____						
Colon Cancer/ Colon polyps						
Ulcerative Colitis/ Crohn's Disease						
Diabetes						
Liver Disease						

**Past Medical History- please check all that apply to you:**

<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Allergies/Hay fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD	<input type="checkbox"/> Congenital Heart Ds.	<input type="checkbox"/> Chest pain/Angina	<input type="checkbox"/> MI	<input type="checkbox"/> Hepatitis _____
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> CHF	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Hypertension
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood clots/DVT	<input type="checkbox"/> Esophageal stricture	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Renal disease	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Menstrual dysfunction
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Stroke/TIA's	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anemia	<input type="checkbox"/> Endocrine Disease	<input type="checkbox"/> Blood transfusion	
<input type="checkbox"/> Cancer _____				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any change in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary healthcare services I (my child) may need.

X \_\_\_\_\_  
Signature of patient /or parent of minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

**Review of Systems (Please check all that apply to you)**

**SKIN**

- Color changes
- Dryness
- Easy Bruising
- Hair loss
- Infection
- Itching
- Nail Problem
- Rashes
- Sores
- Squamous cell cancer

**EYES**

- Blurred vision
- Burning
- Cataracts
- Contacts
- Discharge
- Dryness
- Glaucoma
- Itching
- Pain
- Photophobia
- Redness
- Sclera
- Swelling
- Tearing
- Visual changes

**HEAD/EAR/NOSE/THROAT/MOUTH/NECK**

- Deafness
- Discharge
- Dizziness
- Headaches
- Hoarseness
- Loss of smell
- Nose Bleed
- Post nasal drip
- Sinusitis
- Sore throat
- Tinnitus
- Vertigo

**CARDIAC/RESPIRATORY**

- Bronchitis
- Chest pain
- Cough
- Coughed blood
- Dyspnea
- Hemoptysis
- Mitral valve prolapse history
- Murmurs
- Nocturia
- Orthopnea
- Palpitations
- Phlegm
- Pleuretic chest pain
- Shortness of breath
- Sputum
- Wheezing

**GASTROINTESTINAL**

- Abdominal distention
- Abdominal pain
- Alternating constipation/diarrhea
- Appetite loss
- Belching
- Black tarry stools
- Colon polyps
- Constipation
- Diarrhea
- Dysphagia
- Food intolerance
- Gaseousness
- Heartburn
- Hemorrhoids
- Hepatitis, Type \_\_\_\_\_
- Hernias
- Indigestion
- Jaundice
- Nausea
- Poor appetite
- Rectal bleeding
- Regurgitation
- Vomiting

## GENTOURINARY

- Bloody urine
- Cloudy Urine
- Dark urine
- Dribbling
- Dysuria
- Flank pain
- Frequency of urination
- Hesitancy
- History of UTI's
- HPV
- Impotence
- Incontinent of urine
- Lack of sex drive
- Nocturia
- Painful urination
- Small stream
  
- Stones
- Straining
- Unusual color
- Urethral discharge
- Urgency

## MUSCULOSKELETAL

- Arthritis
- Back pain
- Joint pain
- Joint stiffness
- Leg cramps
- Myalgias
- Spinal stenosis
- Swelling
- Trauma

## HEMATOLOGIC LYMPHACYTIC/BLOOD DISORDERS

- Anemia
- Bleeding
- Easily bruised
- Lymph node enlargement
- Multiple Myeloma
- Other- \_\_\_\_\_

## NEUROLOGICAL

- Depression
- Dizziness
- Gait disorder
- Headaches
- In coordination
- Lack of concentration
- Loss of memory
- Loss of sensation
- Paralysis
- Seizures
- Slurred speech
- Tingling/Burning/Numbing
- Tremors
- Vertigo
- Weak grip

## ENDOCRINE

- Cold intolerance
- Diabetes
- Goiter
- Heat intolerance
- Hyperthyroidism
- Hypothyroidism
- Hypoglycemia
- Other- \_\_\_\_\_

## INFECTION

- Environmental allergies
- History of hives
- Multiple allergies
- Seasonal allergies
- None

## CHILDHOOD ILLNESSES

- Chickenpox
- Measles
- Mumps
- Polio
- Rheumatic fever
- Scarlet fever
- Whooping cough