Desert Gastroenterology Consultants

The office of:

Dr. Gary M. Annunziata / Dr. Anh T. Duong
Dr. Jonathan C. Lin / Natalie Sloan FNP-C
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.

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. **Insurance Contract**
3. **Office Policy**
4. **Patient Medication List (fill out completely, dosage and directions)**
5. **Health History Questionnaire (2pages front and back, total of 4)**
6. **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

DESERT GASTROENTEROLOGY CONSULTANTS

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

PATIENT INFORMATION

GOVERNMENT REQUIREMENT FOR ELECTRONIC HEALTH CARE REPORTING

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

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

ETHINICITY: ☐ 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_____

35-900 BOB HOPE DRIVE SUITE #275, RANCHO MIRAGE, CA. 92270
PHONE (760) 321-2500 FAX (760) 321-5720

Desert Gastroenterology Consultants

The office of:

Gary M. Annunziata, D.O., FACP / Anh T. Duong, M.D.
Jonathan C. Lin, M.D., MPH / Natalie Sloan, FNP

Please note the following are a list of primary insurance companies that Dr. Annunziata, Dr. Duong and Dr. Lin contracted with:

- **Medicare**
- **Blue Cross**
- **Blue Shield**
- **Keenan and Associates**
- **United HealthCare**
- **Triwest Prime- with authorized referral**
- **Triwest/Tricare**
- **4 Your Choice**
- **Aetna**
- **HealthNet**
- **IEHP**
- **Cigna**
- **Kaiser – *Dr. Lin Only.***

Covered California and Exchange Plans please contact your insurance to make sure the doctor is contracted with your specific plan.

If you have insurance coverage with another company that is not listed above, we will bill your insurance company on your behalf, but we ask that you contact your insurance company to obtain any deductible and co-pay information for seeing a provider OUT OF NETWORK.

If you have any questions, contact the office at (760) 321-2500.

By signing below, you have read and understood the above.

_____ _____

Patient Name- Please Print **Date**

_____

Patient's Signature

Gary M. Annunziata, D.O., FACP / Anh T. Duong, M.D.
Jonathan C. Lin, M.D., MPH / Natalie Sloan, FNP-C

35900 Bob Hope Dr., Ste. 275 Rancho Mirage, CA. 92270
Phone- (760) 321-2500 Fax- (760) 321-5720

Patient Name- _____ D.O.B. - _____

Appointment Date/Time- _____ with Dr. _____

Dear Patient,

You have been scheduled for an initial office visit for a screening colonoscopy. Attached are our new patient forms, along with these, we ask that you contact your insurance company PRIOR TO THE INITIAL OFFICE VISIT to determine whether they will cover the initial office visit and a preventative colonoscopy. The procedure codes and diagnosis codes that must be given to the insurance company is as follows:

- ❑ **New patient office visit; 99202.**
- ❑ **Procedure code G0121 with the diagnosis of Z12.11 for the screening purpose of colon cancer.**
- ❑ **Procedure code G0105 with the diagnosis of Z80.0 for the screening purpose due to family history of colon cancer or Z86.010 for a personal history of colon polyps.**

Once you have done so please sign this form and return it along with the others to our office. If you should have any questions, please feel free to contact our office.

Sincerely,
Office Staff

I have contacted my insurance company and inquired about my initial office visit and a screening colonoscopy.

_____ _____

Signature of Patient **Date**

Gary M. Annunziata, D.O., F.A.C.P.
Anh T. Duong, M.D.
Jonathan C. Lin, M.D.
Natalie Sloan, FNP-C.
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Advanced Beneficiary Notice

Medicare, Medi-Cal, and any other insurance carriers will pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of the Medicare Law. If the payer determines that a particular service is not reasonable and necessary under their program, they will deny payment for the service. In your case they may deny payment for the following procedures:

The reason(s) for denial is likely to be one or more of the following:

- Usually does not pay for lab testing and or office visits utilized as a screen to rule out a condition.
- Usually does not pay this many services within this period of time.
- Usually does not pay for testing that are not FDA approved or for the research or experimental purposes only.
- Usually does not pay for routine exam/lab work.
- Other- _____.

Dr. Annunziata, Dr. Duong, or Dr. Lin, have notified me that they believe that payment is likely to be denied, for reason(s) stated above. I agree to personally and am fully responsible for payment and make such payment when billed.

Patient Signature- _____ Date- _____

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 <u>additional charge</u> 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, <u>IT IS YOUR RESPONSIBILITY</u> to call the office. We ask that you <u>never</u> 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):

_____

_____

_____

_____

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

_____
_____
_____

Hospitalization or Surgery—Please indicate date and reason

_____
_____
_____
_____
_____
_____
_____
_____
_____

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:

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

GENITOURINARY

- ❑ **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**
- ❑ **Scarlett fever**
- ❑ **Whooping cough**