Rahim Raoufi, MD
GASTROENTEROLOGY & HEPATOLOGY

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YOUR PERSONAL INFORMATION:

LAST NAME: ______________________ FIRST NAME: ______________________ MI: ______

DOB: ________ - ________ - ________ SSN: ______ - ______ - ______ GENDER: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

PHYSICAL ADDRESS: ______________________ CITY: ______________ STATE: ______

MAILING ADDRESS: ____

HOME PHONE:______________ CELL: ______________ WORK: ______________

EMAIL: ______________________ EMPLOYER: ______________________

PRIMARY CARE PHYSICIAN: ______________________ REFERRED BY: ______________

PREFERRED PHARMACY: ______________________ LANGUAGE: ______________

EMERGENCY CONTACT: ______________________ PHONE: __________ RELATIONSHIP: ________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ____

MEMBER ID #: ______________________ GROUP #: ______________________

NAME OF SPONSOR: ______________________ RELATIONSHIP TO YOU: ______________

DOB: ________ - ________ - ________ SSN: ______ - ______ - ______

SECONDARY INSURANCE: ____

MEMBER ID #: ______________________ GROUP #: ______________________

NAME OF SPONSOR: ______________________ RELATIONSHIP TO YOU: ______________

DOB: ________ - ________ - ________ SSN: ______ - ______ - ______

REASON FOR TODAYS VISIT:

____

____

____

LIST OF CURRENT MEDICATIONS: ____

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MEDICAL HISTORY:

PLEASE CHECK ALL THAT APPLY:

☐ Heartburn / GERD	☐ Fatty Liver	☐ Colon Cancer	☐ Cirrhosis
☐ Spastic Colitis	☐ H. Pylori	☐ Ulcers	☐ Constipation
☐ Celiac Disease	☐ Pancreatitis	☐ Hiatus Hernia	☐ Diverticulitis
☐ Hepatitis	☐ Hemorrhoids	☐ Lactose Intolerance	☐ High Blood Pressure
☐ Gallstones	☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Stool Incontinence
☐ Colon Polyps	☐ Irritable Bowel (IBS)	☐ Gastritis	☐ Diabetes: ☐ Type 1 ☐ Type 2

PLEASE LIST ANY OTHER CHRONIC HEALTH CONDITIONS: ______________________________

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HAVE YOU HAD ANY OF THE FOLLOWING RECENTLY?

☐ Laboratory Testing / Blood Work

☐ Radiology Imaging (X-Ray, Ultrasound, CT Scan, MRI or Barium Studies)

☐ Endoscopies (Upper GI Scope, EGD, ERCP, Colonoscopy or Capsule Endoscopy).

SURGERIES OR HOSPITALIZATIONS: ______________________________

____

FAMILY HISTORY:	LIST FAMILY MEMBER(S) HERE:
☐ Celiac Disease	______________________________
☐ Colorectal Cancer	______________________________
☐ Crohn's Disease	______________________________
☐ H. Pylori	______________________________
☐ Hepatitis A	______________________________
☐ Hepatitis B	______________________________
☐ Hepatitis C	______________________________
☐ Hemochromatosis	______________________________
☐ Stomach Cancer	______________________________
☐ Ulcerative Colitis	______________________________
☐ Uterine Cancer	______________________________

ALLERGIES TO MEDICATIONS:

☐ Codeine	☐ Penicillin	☐ Sulfa	☐ Morphine
☐ Propofol	☐ Demerol	☐ Fentanyl	☐ Versed
☐ Iodine Dye	☐ Surgical Tape	☐ LATEX	☐ No Known Allergies

ARE YOU DIABETIC? ☐ YES ☐ NO ARE YOU INSULIN DEPENDENT? ☐ YES ☐ NO

ARE YOU CURRENTLY ON DIALYSIS? ☐ YES ☐ NO WHAT DAYS? ______________

ARE YOU TAKING BLOOD THINNERS? ☐ YES ☐ NO WHAT DAYS? ______________

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

If YES: How many alcoholic beverages do you consume per day? _______________

How many alcoholic beverages do you consume weekly? _______________

Do you have any problems with alcohol abuse? ☐ YES ☐ NO

HAVE YOU SMOKED OR USED ANY TOBACCO PRODUCTS? ☐ YES ☐ NO

If YES: If you smoke cigarettes, how many packs do you smoke per day?____________

If you use another tobacco product, what type do you use?__________________________________

How many years have you used tobacco?_____________

If you are a CURRENT tobacco user, are you ready or willing to quit? ☐ YES ☐ NO

If you are a FORMER tobacco user, when did you quit?________________

DO YOU DRINK CAFFEINATED BEVERAGES? ☐ YES ☐ NO

If YES, check all that apply: ☐ COFFEE ☐ SODA ☐ TEA ☐ OTHER: _____________________

If YES; How many caffeinated beverages do you normally drink per day?_______________

INSURANCE CLAUSE

I understand that if this or any other visit is not covered by my insurance, I will be held responsible for all fees incurred.

RETURNED CHECK POLICY

A charge of $35.00 will be applied to your account for any returned checks.

TREATMENT CLAUSE

I herby give consent for medical and surgical treatment to Rahim Raoufi, MD to care for myself or anyone I am the guarantor or general agent for.

ASSIGNMENT OF PAYMENT

I herby authorize payment directly to Rahim Raoufi, MD of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

PRIVACY CLAUSE

A person is liable for constructive invasion of privacy when they attempt to capture any type of visual imaging, sound recording or other physical impression of another individual engaging in a personal or familiar activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to civil fine set by the California Civil Code, Section 1708.8

RELEASE OF INFORMATION

I hereby give consent to release to authorized persons, financial and medical information concerning care, treatment and charges therefore as may be required to complete all claims for benefits.

NAME: ____ RELATIONSHIP: ____

NAME: ____ RELATIONSHIP: ____

PATIENT SIGNATURE: ____ **DATE:** ___________________________

PLEASE PRINT NAME: ____