Ming Fang , M. D. INC
675 Ygnacio Valley Rd. Suite B 108 Walnut Creek, CA 94596
Phone: 925-776-7600 FAX: 925-954-8940

Last Name: _____ First Name: _____ Date of Birth: _____

Street Adresss:_____City:_____

Zip:_____ Home Phone: _____ Cell: _____

Email: _____ Gender: Male Female

SSN: _____ Primary Language: _____

Occupation: _____ Employer: _____

Primary Care Doctor: _____ Referring Doctor: _____

Pharmacy Name: _____ Pharmacy Address: _____

Spouse's Name: _____ Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Privacy Disclosure: I authorize Ming Fang MD Inc. to use and/or disclose certain protected health information (PHI) about me including but not limited to Medical history, symptoms, examination, test results, diagnoses, treatment, and future plans for treatment to other health care providers involved in my care, staff involved in my care or billing services, and third party payers, quality assurances of systems or providers, etc. The practice will not receive payment other than the medical services provided or other remuneration from a third party in exchange for using or disclosing the PHI.

Patient's Name (print): _____ Date: _____

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Notice of Financial Policies

Insurance Coverage

Patients are responsible for checking to make sure our physicians participate in their health plan's network. We cannot be responsible for changes in your insurance. Your co-payment is set by your insurance company, and it is due at the time of service. We accept cash, credit cards (VISA/Mastercard) and checks. If we cannot confirm your coverage with your insurance or you are without insurance, we require that you pay in full at the time of service. Patients are responsible for knowing their medical benefits prior to the visit. Please call your insurance to confirm your deductibles, coinsurance and non-covered services.

Please note that the patient is responsible for any deductible, co-insurance, and the remaining payment if there is no secondary insurance, or other costs that may apply.

1. **Our office does not participate in MediCal (Medicaid program); the patient would be responsible for that portion of payment. If you have MediCare and MediCal, you will be responsible for MediCal portion of payment.**

   _____ (initial)

2. **If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services.**

   _____ (initial)

3. **Cancelled and Missed Appointments and Procedures**
   a. Please call us 5 business days in advance if you need to cancel or reschedule your appointment. A $100 fee will be charged for all procedures cancelled without a minimum of 5 business day notice. This cancellation policy helps us keep ambulatory surgery center viable to service you at an affordable cost.

      _____ (initial)

   b. There will be a $50 charge for all no show office visits without a 48 hour notice.

      _____ (initial)

4. **Billing Payments**
   a. Payments shall be received within 30 days of initial statement. 12% annual interest will be added if not paid on time.

      _____ (initial)

5. **Deposits ($100) for procedures**
   a. Effective Jan 1, 2017, our office is requiring a $100 deposit for procedures. Deposit will be collected at the time of office visit.
   b. Deposits collected will be held until payment received from insurance. If patient has balance owed, we will apply deposit to balance.

      _____ (initial)

_____ _____

Patient/Guarantor's Name (Signature) Date

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Medical History

Primary Care Doctor: _____ Reason for Visit: _____

1) Have you ever experienced or diagnosed:

Esophagus
□ Swallowing Problems (difficulty or pain)
□ GERD (heartburn, regurgitation)
□ Chest Pain
□ Chronic Cough

Hemorrhoids
□ Anal Pressure/Pain/itchy/protruding

Stomach
□ Nausea
□ Vomiting
□ Ulcer
□ Early fullness after eating
□ Pain after eating

Colon
□ Colon Polyps
□ Rectal Bleeding
□ Blood in Stool
□ Diverticulosis
□ Ulcerative Colitis
□ Crohn's Disease
□ Constipation
□ Date of Last colonoscopy _____

General/Other
□ Pancreatitis
□ Celiac Disease
□ Weight Loss
□ Diarrhea
□ Abdominal Pain
□ Anemia
□ Black/Tarry Stool
□ Bloating/Gas

Liver/bile duct
□ Jaundice
□ Abnormal Liver Test
□ Hepatitis (A,B,C, etc.)
□ Cirrhosis
□ Liver Cyst or Mass
□ Gallstones

2) Have you developed any of the following symptoms within the last 30 days? Circle the following:
None Fever Rash Cough Diarrhea Body Ache Headache Other: _____

3) Have you been exposed to or been around a sick person within the last 30 days? □ Yes □ No
If yes, where? _____

4) Have you traveled within the last 30 days? □ Yes □ No
If yes, where? _____

5) List any medications you are allergic to (list your reactions as well):
□ No Known Drug Allergies □ Sulfa □ Penicillin □ Latex
□ Other _____ Reaction: _____

6) Please list all prescriptions and over the counter medications you take. Ask for an additional sheet if needed.

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

7) Check the box next to any of below health problems that you have

Cardiovascular
□ AICD or Pacemaker
□ Atrial Fibrillation (Afib)
□ Myocardial Infarction (MI or heart attack)
□ Coronary Artery Disease (CAD)
□ Congestive Heart Failure (CHF)
□ Stroke/Transient Ischemic Attack (TIA)
□ Peripheral Vascular Disease (PVD)

Lung
□ COPD/Emphysema
□ Sleep Apnea

Other
□ Diabetes
□ Chronic Kidney Disease (CKD)
□ Seizures
□ Hyperthyroidism
□ Hypothyroidism
□ Hypertension
□ High Cholesterol
□ Cancer (Type: _____)

_____ _____
Patient's Name (Print) Date

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8) Any other health problems that you have? _____

9) List all surgeries you have had:
□ Gallbladder □ Appendix □ Hysterectomy □ Bowel Surgery
□ Other: _____

10) Family History:
a. Has anyone in your family had colon cancer? □ Yes □ No
If yes, who and what age? _____
b. Has anyone in your family had colon polyps? □ Yes □ No
If yes, who and what age? _____
c. Has anyone in your family developed ovarian or uterine cancer? □ Yes □ No
If yes, who? _____
d. Do you have a parent or sibling who has had stomach cancer? □ Yes □ No
If yes, who? _____
e. What health problems do your parents and siblings have? _____

11) Are you currently experiencing any of the below?
□ None

General
□ Weight Loss
□ Night Sweats

Eyes
□ Double Vision
□ New Vision Changes

HEENT
□ Sore Throat
□ Hearing Loss
□ Congestion

Endo
□ Sweating
□ Cold Intolerance
□ Heat intolerance

Allergies
□ Eczema
□ Hives
□ Rhinitis
□ Asthma

Skin
□ Rash
□ Itching

Cardio
□ Chest Pain
□ Palpitations
□ Swelling in Legs

Neuro
□ Dizziness
□ Weakness
□ Seizures
□ Headaches

MSK
□ Muscle Aches
□ Painful Joints
□ Back Pain

Hem/Onc
□ Bruising
□ Anemia
□ Bleeding

Respiratory
□ Shortness of Breath
□ Cough
□ Coughing Blood

GU
□ Blood in Urine
□ Frequent Urination

Psych
□ Depression
□ Psychosis
□ Anxiety

12) Social History
a. Are you a: □ Current smoker □ Former smoker (quit date: _____) □ Nonsmoker
- Are you interested in quitting? □ Yes □ No
- How many packs of cigarettes per day do you smoke? _____

b. Do you drink alcohol? □ Yes □ No
- If yes, how many drinks of alcohol do you have per week on average? _____

c. Have you used drugs other than those for medical reasons in the past 12 months? □ Yes □ No
- If yes, which drugs? _____

_____ _____

Patient's Name (Print) Date