PATIENT DEMOGRAPHICS

REFERRING DOCTOR'S NAME: _____

NAME: _____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: _____

CITY: _____ **ZIP:** _____

HOME TELEPHONE: _____ **WORK TELEPHONE:** _____

MARITAL STATUS: S___ M ___ D ___ W ___ OTHER TELEPHONE: _____

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____

EMPLOYER NAME: _____ **OCCUPATION:** _____

WORK ADDRESS: _____ **CITY:** _____ **ZIP:** _____

NAME OF SPOUSE: _____

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____

SPOUSE'S EMPLOYER: _____ **OCCUPATION:** _____

WORK ADDRESS: _____ **CITY:** _____ **ZIP:** _____

SPOUSE'S WORK TELEPHONE: _____

IN CASE OF EMERGENCY NOTIFY: _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

TELEPHONE: _____ **RELATIONSHIP:** _____

INSURANCE

PRIMARY: _____ **SECONDARY:** _____

IF MINOR: INSURED'S NAME: _____ **INSURED'S DOB:** _____

INSURED'S EMPLOYER: _____

****

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ YES ☐ NO The facility has an Advanced Directive Policy. The policy informs the patient to make informed decisions. This is part of the informed consent we obtain before any endoscopic procedures. The facility does not honor "DO NOT RESUSCITATE" directive.

PRIMARY LANGUAGE SPOKEN: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE. I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO *SUDIN VITTAL MD, INC./HARSHA VITTAL, M.D.* THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

SIGNATURE: _____ **DATE** _____

(REV. 09/16)

SOUTH BAY GI, INC.

HARSHA VITTAL, M.D.
DIPLOMATE, AMERICAN BOARD
INTERNAL MEDICINE AND GASTROENTEROLOGY

GASTROENTEROLOGY, HEPATOLOGY, ADVANCED THERAPEUTIC ENDOSCOPY

150 N. JACKSON AVE., SUITE 107
SAN JOSE, CA 95116
OFFICE: (408) 926-2182
FAX: (408) 926-8370

15215 NATIONAL AVENUE #101
LOS GATOS, CA 95032
OFFICE: (408) 926-2182
FAX: (408) 926-8370

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown
- ☐ Patient declines to specify

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to specify

Preferred Language

- ☐ English
- ☐ Patient declines to specify

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Dairy Products
- ☐ Latex
- ☐ Morphine
- ☐ Penicillins
- ☐ Shellfish
- ☐ Vicodin
- ☐ midazolam
- ☐ fentanyl citrate
- ☐ Sulfa (Sulfonamide Antibiotics)
- ☐ codeine-guaifenesin

Current Medications

- ☐ None

Name	Dose	How taken?

Social History

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other

Alcohol

- ☐ None
- ☐ Patient consumes alcohol — Type | Quantity | Number | Frequency

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

Drug Use

- ☐ None

Pharmacy

Name | Address | Phone

SOUTH BAY GI, INC.
HARSHA VITTAL, M.D.
DIPLOMATE, AMERICAN BOARD
INTERNAL MEDICINE AND GASTROENTEROLOGY

GASTROENTEROLOGY, HEPATOLOGY, ADVANCED THERAPEUTIC ENDOSCOPY

150 N. JACKSON AVE., SUITE 107
SAN JOSE, CA 95116
OFFICE: (408) 926-2182
FAX: (408) 926-8370

15215 NATIONAL AVE #101
LOS GATOS, CA 95032
OFFICE: (408) 926-2182
FAX: (408) 926-8370

South Bay GI Inc. Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At South Bay GI Inc. we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information (i.e. appointment date and time) on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing, that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may nor make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the change in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Dr. Harsha Vittal at (408) 926-2182.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the South Bay GI Inc. Notice of Privacy Practices. Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____

SOUTH BAY GI, INC.
HARSHA VITTAL, M.D.
DIPLOMATE, AMERICAN BOARD
INTERNAL MEDICINE AND GASTROENTEROLOGY

GASTROENTEROLOGY, HEPATOLOGY, ADVANCED THERAPEUTIC ENDOSCOPY

150 N. JACKSON AVE., SUITE 107
SAN JOSE, CA 95116
OFFICE: (408) 926-2182
FAX: (408) 926-8370

15215 NATIONAL AVE #101
LOS GATOS, CA 95032
OFFICE: (408) 926-2182
FAX: (408) 926-8370

Sudin Vittal M.D. Inc. Endoscopy Center

Policy and Governance

Thank you for coming to our office for a Gastrointestinal evaluation. I am a Board Certified Physician specializing in the treatment of Gastrointestinal and Liver Disease.

Our history and physical examination, by and large, will be confined to the Digestive system. After the examination and review of any tests that have already been done, I will advise you of further testing that might have to be performed. You will be given enough opportunity to ask me questions regarding the tests and the treatment plan. If you so desire, you can obtain a second opinion.

Once the tests are ordered by me, it is your responsibility to follow through with them, such as scheduling Barium studies and scans in the X-ray Department or having blood tests done in the lab. My office staff will do the endoscopy scheduling for you in our Accredited Endoscopy Center which is licensed by the State and Federal Government. The physicians and the support staff abide by applicable Federal & State laws and regulations. Literature regarding various intestinal and liver disease are generally available in our office.

Please make sure you call our office within 5-7 days after the tests are done to be informed of the results. At that time, you will have an opportunity to discuss further, regarding your condition, as well as bring any complaints to our attention; the latter will receive our proper attention and you will hear a response.

Most of our patients belong to a HMO with which your physician has a contract for total payment (except the co-payment by the patient). Under these circumstances, you will not receive a bill. If on the other hand, you are responsible for certain payments, a statement will be sent to you at the end of the month.

If you come across any problems regarding our services, you can contact the office manager, Mrs. Filomena Simpson or myself.

The medical records are securely kept in our office. Your medical records will only be released to another physician or an insurance company or anyone you designate, only after obtaining your duly signed release form.

It is our policy to see no one under 16 year's of age. If the patient is under the age of 18 years of age or mentally impaired, we require a parent, guardian or conservator to be with the patient and to sign consent.

My office staff and myself are dedicated to providing courteous and quality specialized care to our patients. Your suggestions are always welcome.

Disclosure of Financial Interest

Dr. Sudin Vittal is the sole owner of the Sudin Vittal, M.D., Inc. Endoscopy Center. No one else has any financial interest in the facility. The Endoscopy Center operates exclusively for the purposes of providing G.I. endoscopic procedures to patients not requiring hospitalization. Patients stay do not exceed business hours.

Thank you for your cooperation.

Sudin Vittal, M.D.
Harsha Vittal, M.D.

I have read and understand the above policy of your office.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF PARENT/GUARDIAN/CONSERVATOR: _____

cc: patient
chart

Rev. 09/16