PATIENT BASIC INFORMATION

Last:_____ First:_____ Middle:_____ Date:_____

Address: _____ DOB:_____

Address 2:_____ Gender: □ Male

City: _____ State:_____ Zip:_____ □ Female

Cell:_____ Tel:_____ Referred By:_____

SSN (Optional):_____ Driver License:_____ Language:_____

Marital Status:

□ M-Married

□ S-Single

□ O-Other

Ethnicity:

□ H-Hispanic

□ N-Not Hispanic

Smoking Status:

□ 1-Current Every Day Smoker

□ 2-Current Some Day Smoker

□ 3-Former Smoker

□ 4-Never Smoked

□ 5-Smoker, Current Status Unknown

□ 6-Unknown If Ever Smoked

Race:

□AIAN-American Indian or Alaska Native

□ASIAN

□BLACK

□ NHPI-Native Hawaiian or Pacific Islander

□ White

e-mail:_____

Emergency Contact:_____ Rel:_____ Tel:_____

INSURANCE COVERAGE DETAIL (PRIMARY)

Insurance:_____ Insurance ID:_____

Relationship to Insured: □ Self Copy of Card? □Yes

□ Spouse □ No

□ Other:_____

INSURANCE COVERAGE DETAIL (SECONDARY)

Insurance:_____ Insurance ID:_____

Relationship to Insured: □ Self Copy of Card? □Yes

□ Spouse □ No

□ Other:_____

EMPLOYER INFORMATION

Employer:_____ Tel:_____

Address:_____

City:_____ State:_____ Zip:_____

PLEASE SIGN THE FOLLOWING FORM

I hereby authorize **ROKAY KAMYAR, M.D., INC** or **MAHMOUD LAJIN M.D.** to furnish to my insurance company or to a designated attorney, all information which the insurance company or attorney request. I hereby assign to the above-referenced physicians all monies to which I am entitled for services rendered by any of them. I understand I am financially responsible, WHETHER MY INSURANCE COMPANY PAYS OR NOT, for all charges incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and/or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

_____ _____ _____

Insured or Guardian Signature | Patient's Signature | Date

ROKAY KAMYAR, M.D., INC
MAHMOUD LAJIN, M.D.
Diplomate American Board of Gastroenterology

PATIENT'S PERSONAL HISTORY FORM

NOTE: This is a confidential record and will be kept in this facility or your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

NAME _____ Age _____ ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) Date _____

Occupation _____ Birthplace _____ Birthdate _____

Dr. _____ Date of last Physical Examination _____

List all States and Countries in which you have lived _____

List all Countries you have visited in the past 12 months _____

Education: _____Years High School _____Years College _____Years Post Grad

Chief complaints: (Please list all symptoms.)

1. _____ 3. _____

2. _____ 4. _____

FAMILY HISTORY

Do You Have Blood Relatives with:

Cancer, Including Leukemia	☐
Tuberculosis	☐
Diabetes	☐
Heart Trouble	☐
Heart Attack	☐
High Blood Pressure	☐
Stroke	☐
Epilepsy	☐
Bleeding Disorder	☐
Asthma	☐
Allergies	☐
Liver Disease	☐
Migraine Headaches	☐
Alcoholism	☐
Emphysema	☐
Stomach or Duodenal Ulcer	☐
Kidney Disease	☐
Glaucoma	☐
Sickle Cell Anemia	☐
Other Anemia	☐
Mental Illness	☐
Suicide	☐
Birth Defects	☐
Alzheimer Disease	☐
Other Serious Disease	☐

PERSONAL HISTORY

Do You Smoke? ☐ NO ☐ YES

If Yes, What _____

How Much _____

Formerly Smoked ☐ NO ☐ YES

How Many Years _____

Average Packs per Day _____

When did You Stop? _____

Do You Drink Alcoholic Beverages? ☐ NO ☐ YES

Do You Wear Seatbelts in an Automobile? ☐ NO ☐ YES

Do You Use Sunscreen? ☐ NO ☐ YES

SOCIAL HISTORY

Who Do You Live with? _____

Does Your Family Live Close By? ☐ NO ☐ YES

Are You on a Special Diet? ☐ NO ☐ YES,

What Type? _____

Has Your Weight Changed in the Past Year? ☐ NO ☐ YES, _____lbs.

	IF LIVING		IF DECEASED	
	Age	Health	Age of Death	Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				

DO YOU *NOW* HAVE ANY OF THE FOLLOWING COMPLAINTS?

General

Fever, Chills	☐ NO	☐ YES
Aches or Pains	☐ NO	☐ YES
General Weakness	☐ NO	☐ YES
Memory Loss	☐ NO	☐ YES
Swollen Glands	☐ NO	☐ YES
Easy Bruising	☐ NO	☐ YES

Head

Blurred Vision Not Corrected by Glasses	☐ NO	☐ YES
Double Vision	☐ NO	☐ YES
Light Flashes	☐ NO	☐ YES
Halos Around Lights	☐ NO	☐ YES
Eye Pain	☐ NO	☐ YES
Ear Pain	☐ NO	☐ YES
Drainage from Ear	☐ NO	☐ YES
Hearing Difficulty or Deafness	☐ NO	☐ YES
Buzzing or Ringing in Ears	☐ NO	☐ YES
Nosebleeds Not Due to Injuries	☐ NO	☐ YES
Sinus Trouble	☐ NO	☐ YES
Mouth, Tooth or Tongue Problem	☐ NO	☐ YES
Persistent Hoarseness	☐ NO	☐ YES
Severe Headaches	☐ NO	☐ YES

Skin

Changing Mole	☐ NO	☐ YES
Rash	☐ NO	☐ YES
Yellow Skin	☐ NO	☐ YES

Neck

Swelling	☐ NO	☐ YES
Lumps	☐ NO	☐ YES
Stiffness	☐ NO	☐ YES

Chest, Heart, Lungs

Shortness of Breath	☐ NO	☐ YES
Poor Exercise Tolerance	☐ NO	☐ YES
Fluttering of Heart	☐ NO	☐ YES
Unusual Heartbeat	☐ NO	☐ YES
Chest Pain or Pressure Attacks	☐ NO	☐ YES
Frequent Cough	☐ NO	☐ YES
Coughing Up Blood	☐ NO	☐ YES
Wheezing	☐ NO	☐ YES
Night Sweats	☐ NO	☐ YES
Swollen Ankles	☐ NO	☐ YES
Leg Cramps	☐ NO	☐ YES

Gastrointestinal

Poor Appetite	☐ NO	☐ YES
Indigestion or Heartburn	☐ NO	☐ YES
Difficulty Swallowing	☐ NO	☐ YES
Nausea or Vomiting	☐ NO	☐ YES
Vomiting Blood	☐ NO	☐ YES
Abdominal Pain or Cramps	☐ NO	☐ YES
Abdominal Swelling	☐ NO	☐ YES
Diarrhea	☐ NO	☐ YES
Constipation	☐ NO	☐ YES
Change in Bowel Habits	☐ NO	☐ YES
Pass Blood from Rectum	☐ NO	☐ YES
Black, Tar-like Bowel Movements	☐ NO	☐ YES

Kidney

Blood in Urine	☐ NO	☐ YES
Pain or Burning while Urinating	☐ NO	☐ YES
Difficulty Passing Urine	☐ NO	☐ YES
Difficulty Controlling Urine	☐ NO	☐ YES
Getting Up at Night to Urinate	☐ NO	☐ YES

Women

Breast Lump	☐ NO	☐ YES
Discharge from Nipple	☐ NO	☐ YES
Other Breast Problem	☐ NO	☐ YES
Vaginal Bleeding, Spotting, or Discharge (not with periods)	☐ NO	☐ YES
Hot Flashes	☐ NO	☐ YES
Pain with Intercourse	☐ NO	☐ YES
Possibly Pregnant	☐ NO	☐ YES
Change in Periods	☐ NO	☐ YES
Pain not Associated with Periods	☐ NO	☐ YES

Men

Breast Lump	☐ NO	☐ YES
Discharge from Penis	☐ NO	☐ YES
Sore on Penis	☐ NO	☐ YES
Lump in Testicles	☐ NO	☐ YES
Difficulty Having Erections	☐ NO	☐ YES

Neuromuscular

Weakness in Arm or Leg	☐ NO	☐ YES
Difficulty with Balance	☐ NO	☐ YES
Dizzy Spells	☐ NO	☐ YES
Fainting Spells	☐ NO	☐ YES
Speech Difficulty	☐ NO	☐ YES

Bones-Joints

Painful or Swollen Joints	☐ NO	☐ YES
Loss of Muscle Strength	☐ NO	☐ YES
Lump or Swelling in Muscle or Bone	☐ NO	☐ YES
Back Pain	☐ NO	☐ YES

Endocrine

Thirsty All the Time	☐ NO	☐ YES
Too Warm or Cold Most of the Time	☐ NO	☐ YES
Unusually Sluggish or Nervous	☐ NO	☐ YES

Psychologic

Do You Find Your Life:		
Generally Unsatisfactory	☐ NO	☐ YES
Generally Satisfactory	☐ NO	☐ YES
Do You Have Problems with:		
Money	☐ NO	☐ YES
Job	☐ NO	☐ YES
Marriage	☐ NO	☐ YES
Home Life	☐ NO	☐ YES
Children	☐ NO	☐ YES
Sexual Relations	☐ NO	☐ YES
Do You:		
Often Feel Depressed	☐ NO	☐ YES
Have Difficulty Sleeping	☐ NO	☐ YES
Feel Anxious or Upset	☐ NO	☐ YES
Have You:		
Seriously Considered Suicide	☐ NO	☐ YES
Attempted Suicide	☐ NO	☐ YES

Other Current Concerns?

_____

_____

_____

_____

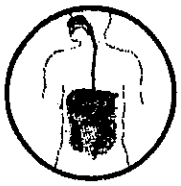
_____

_____

PATIENT NAME:_____ DOB:_____

MEDICATION SHEET

NAME OF MEDICATION (Example: Prilosec	DOSE 20mg	TIMES PER DAY 1 each day)



CENTER *for* DIGESTIVE DISORDERS

TO OUR PATIENTS REGARDING HEALTH CARE CHANGES

If your health insurance changes in 2015, it is your responsibility to let us know. If you have any appointments such as office visits or procedures in 2015 and your insurance is changing, please let us know before your appointment date.. If we are not informed you will be held responsible for any charges incurred. Remember we are not providers for all insurance policies so it is very important that you inform us.

Rokay Kamyar, M.D.
Mahmoud Lajin, M.D.

I have received and read this notice and understand its contents.

Signature Date

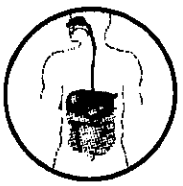
Rokay Kamyar, M.D., D.M.Sc., F.A.C.G., A.G.A.F.
Diplomate of American Boards of
Internal Medicine and Gastroenterology

Mahmoud Lajin, M.D., F.A.C.P., F.A.C.G.
Diplomate of American Boards of
Internal Medicine and Gastroenterology

Abha M. Bosworth, MPH, MS, PA-C
Jennifer Shin, MS, PA-C
Physician Assistants

Tel: 619-460-4055, Fax: 619-460-5148

8860 Center Dr., Suite 330, La Mesa, CA 91942



ROKAY KAMYAR, M.D. Inc.

CENTER *for* DIGESTIVE DISORDERS

Dear Patient:

This office knows that insurance plans can be complicated and we will make every effort to answer your questions, but it is your responsibility to know the requirements of your plan. Please inform us if your plan requires you to use a contracted lab, a special radiology group, or a particular group of doctors/hospitals. In addition, if your health plan requires you to obtain a referral before seeking care here, please be sure to do so. Again, it is your responsibility to know the procedures and protocols.

We deal with over 700 different plans, and each has different requirements and benefits. We just can't know the details of all health plans.

We ask that you read your health plan book carefully and understand your coverage and any restrictions. If your plan requires pre- authorization before any out-patient procedures, please let us know. You must instruct our staff as to the particulars of your plan at the time of your visit.

All patients must pay their copay at the time of their visit. If we need to bill you for the copay an additional $10.00 will be added to your bill . Dr. Kamyar accepts Visa, Master Card and Discover Card as well as personal checks and cash. Dr. Lajin accepts personal checks and cash only.

Thank you,

Rokay G. Kamyar, M.D.
Mahmoud Lajin, M.D.
Abha Bosworth, PA-C

I certify that I have received the above information on _____
Date/Initials

Rokay Kamyar, M.D., D.M.Sc., F.A.C.G., A.G.A.F.
Diplomate of American Boards of
Internal Medicine and Gastroenterology

Mahmoud Lajin, M.D., F.A.C.P., F.A.C.G.
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Physician Assistant

Tel: 619·460·4055, Fax: 619·460·5148

8860 Center Dr., Suite 330, La Mesa, CA 91941

ROKAY KAMYAR, M.D., INC
MAHMOUD LAJIN, M.D.
Diplomate American Board of Gastroenterology

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name_____

Date of Birth_____Social Security_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the many healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and surgical information to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare options such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

1. To object to the use of my health information for directory purposes.
2. To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
3. To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Signature of Patient:_____

Date:_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative:_____

Describe Personal Representative

Relationship(parent, guardian, ect_:_____

Signature of Personal Representative:_____

Date:_____

Signature of Practice Employee_____Date_____