***Endoscopy Center of Marin*** ***Fax: (415) 895-5870*** ***Phone: (415) 472-9945***

## PATIENT REGISTRATION

PLEASE VERIFY ALL INFORMATION AND MAKE CORRECTIONS ON FORM AS NEEDED

PATIENT NAME: DOB:

ADDRESS: SSN #:

CITY: STATE: ZIP: HOME PHONE:

EMPLOYER: CELL PHONE:

PRIMARY CARE PHYSICIAN: EMAIL ADDRESS:

OTHER PHYSICIANS: (i.e. Oncology, Gynecology, etc.)

## CALIFORNIA STATE REPORTING REQUIREMENTS

RACE: Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Asian Pacific American ☐

Pacific Islander ☐ American Indian or Alaskan Native ☐ Native Hawaiian ☐ Black Non-Hispanic ☐

White Non-Hispanic ☐ Other Race ☐ More than one race ☐ Not Reported/Refused ☐ Unknown ☐

ETHNICITY: Latino/Hispanic ☐ Other ☐

PRIMARY LANGUAGE: English ☐ Spanish ☐ Other (please specify): _____

## EMERGENCY CONTACT

NAME: PHONE:

RELATIONSHIP:

## INSURANCE INFORMATION

PRIMARY INSURANCE: NAME OF INSURED: DOB:

POLICY #: GROUP #:

SECONDARY INSURANCE: GROUP #:

☐ *I WISH TO RECEIVE BILLING INFORMATION VIA EMAIL (Check box)*

IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE DR. BAZALGETTE, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE DENIES PAYMENT – DUE TO NO REFERRAL – YOU, THE PATIENT, AGREE TO PAY THE ENDOSCOPY CENTER OF MARIN IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

## ADVANCED MEDICAL DIRECTIVE INFORMATION

It is the policy of this center that in the absence of an applicable properly executed Advance Directive, on file, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

PATIENT SIGNATURE:_____ DATE:_____

***Endoscopy Center of Marin***

PATIENT HEALTH HISTORY FORM

LATEX ALLERGY: Y N
FOOD ALLERGIES: Y N
Please list:
_____
_____

MEDICATION ALLERGIES Y / N
Please list and indicate reactions:
_____
_____
_____

CURRENT MEDICATIONS
Please list or attach: _____
_____
_____
_____
_____
Do you take anti-coagulants or use high-dose aspirin, Lovenox, Plavix, Pradaxa regularly? □ Y □ N

CARDIOVASCULAR ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Chest pain |
| □ | □ | Congestive heart failure |
| □ | □ | History of MI (heart attack) |
| □ | □ | High triglycerides |
| □ | □ | High blood pressure |
| □ | □ | Arrhythmia |
| □ | □ | Valve disease |
| □ | □ | Stroke |
| □ | □ | Coronary artery disease |
| □ | □ | Edema |

PULMONARY ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Asthma |
| □ | □ | Pneumonia |
| □ | □ | Sleep Apnea |
| □ | □ | Loud snoring |
| □ | □ | Bronchitis |
| □ | □ | Productive cough |
| □ | □ | Shortness of breath |
| □ | □ | Tuberculosis |
| □ | □ | Recent chest cold |

Have you had any problems with anesthesia in the past?
□ Y □ N

GI ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Chewing difficulty |
| □ | □ | Crohn's |
| □ | □ | Gall bladder |
| □ | □ | Hemorrhoids |
| □ | □ | Polyps |
| □ | □ | Unexplained weight loss |
| □ | □ | Cirrhosis |
| □ | □ | Diarrhea |
| □ | □ | Gastric reflux |
| □ | □ | Hiatal hernia |
| □ | □ | Swallowing problems |
| □ | □ | Constipation |
| □ | □ | Pers/Family Hist Colon Cancer |
| □ | □ | Hepatitis |
| □ | □ | Jaundice |

RENAL ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Kidney stones |
| □ | □ | Renal insufficiency |
| □ | □ | Other: |

_____

DIABETES Y / N
Treated with…
□ DIET □ INSULIN □ ORAL MEDS
□ OTHER: _____
LAST BLOOD SUGAR READING…
_____

ENDOCRINE ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Thyroid problem |
| □ | □ | Adrenal Disease |
| □ | □ | Hyper-thyroid |
| □ | □ | Hypo-thyroid |
| □ | □ | |

Other:_____

SMOKER Y / N

AMOUNT PER DAY _____

DRUG USE Y / N
Daily □ Weekly □ Seldom □

ALCOHOL USE Y / N
Daily □ Weekly □ Seldom □

NEURO/MUSCULOSKELETAL ISSUES

| Y | N | |
|---|---|---|
| □ | □ | Headaches |
| □ | □ | MS |
| □ | □ | Paralysis |
| □ | □ | Neck/back pain |
| □ | □ | Seizures |
| □ | □ | Arthritis |
| □ | □ | Migraines |
| □ | □ | Other: _____ |

OTHER

| Y | N | |
|---|---|---|
| □ | □ | Anemia |
| □ | □ | Auto-immune issues |
| □ | □ | Bleeding disorders |
| □ | □ | Lupus |
| □ | □ | Steroid use |
| □ | □ | Cancer, please specify: _____ |

_____
_____

IMPLANTS / PROSTHETICS / REMOVABLE DENTAL WORK
Y / N
If yes, please specify: _____
_____

PREGNANT OR POSSIBLE PREGNANCY

□ Y □ N □ N/A

PRIOR SURGERIES

□ N
□ Y, please list:
_____
_____
_____

| | |
|---|---|
| Height: _____<br>Weight: _____ | In the past 3 weeks, have you had a fever or illness after traveling overseas?<br>□ Y □ N |

Office use only: V NV LM

A_____ DC _____

PATIENT SIGNATURE: DATE:

***Endoscopy Center of Marin***

# PATIENT ANESTHESIA QUESTIONNAIRE

● Dr. Mark B. Bazalgette, M.D. ● 165 Rowland Way, Suite 200, Novato, CA 94045 ●

PATIENT NAME: _____ D.O.B.: _____

***Should you need a procedure, these questions help ensure your safety and comfort.***

What is your current weight? _____ What is your current height? _____

| | | |
|---|---|---|
| Have you been diagnosed with Sleep Apnea? | □ Yes | □ No |
| If yes, did you have a sleep study completed? | □ Yes | □ No |
| Was a CPAP machine recommended? | □ Yes | □ No |
| Do you use the CPAP machine? | □ Yes | □ No |

➔ If yes, you must inform the staff of the setting on the machine. (Write here.) _____

| | | |
|---|---|---|
| Are you receiving dialysis? | □ Yes | □ No |
| Are you pregnant? | □ Yes | □ No |
| Do you use oxygen at home? | □ Yes | □ No |
| Do you take insulin? | □ Yes | □ No |
| Have you ever had a problem with sedation or anesthesia? | □ Yes | □ No |
| Do you have a breathing or lung condition? | □ Yes | □ No |

If yes, please check the most suitable box to describe the condition.

□ Asthma □ COPD □ Restrictive lung disease □ Lung surgery

| | | |
|---|---|---|
| Do you have heart problems? | □ Yes | □ No |

If yes, please check box to best describe condition:

□ Heart attack □ Coronary artery disease □ Heart valve disease □ Congestive heart failure

When did you last see your cardiologist?

Have you had any of the following heart procedures?

| | | |
|---|---|---|
| Coronary artery stent placement? | □ Yes | □ No |
| Coronary artery bypass surgery (CABG)? | □ Yes | □ No |
| Pacemaker placement? | □ Yes | □ No |
| Implantable defibrillator placement? | □ Yes | □ No |
| Do you take any anticoagulants? | □ Yes | □ No |

(Coumadin/warfarin, Xarelto/rivaroxaban, Elquis/apixaban, Pradaxa/dabigatran, Savaysa/edoxaban)

| | | |
|---|---|---|
| Do you take Aspirin every day? | □ Yes | □ No |
| Do you take anti-platelet medications? | □ Yes | □ No |

(Plavix/clopidogrel, Effient/prasugrel, or Aggrenox/dipyridamole)

| | | |
|---|---|---|
| Have you ever had an anaphylactic reaction to latex? | □ Yes | □ No |

PATIENT SIGNATURE: DATE:

***Endoscopy Center of Marin***

## CANCELLATION AND NO-SHOW POLICY

*Our goal is to provide quality individualized medical care. No-shows and late cancellations (less than seven days/ notice) inconvenience both facility personnel and physicians but also inconvenience those individuals who need access to medical care in a timely manner.*

*Our office policy is that if you do not notify us* **seven days in advance** *of your need to cancel or re-schedule your appointment, a* **late cancellation fee of $100.00** *will be charged. This courtesy makes it possible to give your reserved time to another patient who needs our care.* **This fee must be paid prior to rescheduling.**

*We know your time is valuable and that there may be special unavoidable circumstances that may cause you to cancel; however, in order to be respectful of the medical needs of other patients, please be courteous and call our scheduling department promptly at (415) 925-8900 to cancel your appointment.*

## INFORMATION FOR PREPARATION

The Endoscopy Center of Marin has detailed information about what to expect before, during, and after the procedure as well as links to educational resources about colonoscopy and colon cancer screening on their website at www.ecmarin.com.

Should you have any further questions about preparation, please contact Dr. Bazalgette's office at (415) 472-9945.

## SIGNATURE AND AUTHORIZATION

I verify that I have read and understand all the above.

PATIENT SIGNATURE: DATE:

# Mark Bazalgette, M.D.

165 Rowland Way, Suite 200 • Novato, CA 94945

Office: (415) 472-9945 · Fax: (415) 895-5870


| PLEASE NOTE: ⚠ | This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. |
|---|---|

## Patient Health Questionnaire

Please complete this form in its entirety to the best of your ability. If something is not applicable, you may write "N/A". Thank you.

Name:_____ DOB:_____

| | |
|---|---|
| What medical concerns bring you to our office? | |
| Please list current medical conditions/illnesses **NOT** related to your visit with Dr. Bazalgette. (e.g.: high blood pressure, type II diabetes, chronic back pain, osteoporosis, etc.) | ☐ None |
| Do you have a history of cancer? | ☐ Yes ☐ No |
| If yes, please list type and year of diagnosis. | |
| Please list any prior colon or rectal procedures (with approximate dates). | ☐ None |
| List any major operations, surgeries, or hospitalizations (and year) for other problems. | |
| List any members of your family who have had colorectal cancer. | ☐ None |
| Have you had a colonoscopy before? | ☐Yes ☐No<br>☐3 years ago ☐5 years ago<br>☐10 years ago ☐Other: _____ |

| | |
|---|---|
| If yes, physician/facility who performed your last colonoscopy. | |
| Have you ever had anesthesia complications? | ☐ Yes ☐ No |
| Are you taking any blood thinning medications? | ☐Coumadin (Warfarin) ☐Effient ☐Eliquis<br>☐Aspirin ☐Pradaxa ☐Plavix<br>☐Xarelto ☐Other: _____ |
| Do you have a pain management contract? | ☐ Yes ☐ No |
| If yes, which doctor or hospital? | |

## Current Medications

| Medication | Dose | Prescribed For |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

## Allergies

| Medication, Solution, or Metal Name | Allergic Reaction |
|---|---|
| Latex | ☐ Yes ☐ No |
| 1. | |
| 2. | |
| 3. | |

_____

Full Name Date

# Authorization to Release Medical Information

***What is this form? -*** This is an authorization form that, when you sign it, allows us to access any records we may need from other doctors who take care of you. For example, your primary care physician, or a facility where you underwent surgery or blood tests. We do **not** use this form to send and receive your private information out at random. We will make sure we have your complete consent before we request anything. This form also allows us to send records of your visit to this office to your primary care physician - they really appreciate it when we keep them up to date on your visits!

Name of Patient | Date of Birth

Address | City | State | Zip

Phone Number | Last 4 Digits of SSN:

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, or family member to release health information about me:

Person/Organization to Release Information

Address | City | State | Zip

Phone Number | Fax Number

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record from the above persons or organizations:

*Dr. Mark B. Bazalgette, M.D.*
*165 Rowland Way, Suite 200*
*Novato, CA 94945*
*Phone (415) 472-9945  Fax (415) 895-5870*

The following health information that relates to service beginning from _____to_____may be released:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Hospital Reports
- ☐ Medication List
- ☐ Treatment Record
- ☐ Operation Reports
- ☐ Other (please specify):

- The above person/organization receiving my medical information, its employees, representatives, and any other persons performing services for them or on their behalf, may need to obtain, use, or disclose any and all information about my physical and mental health, including but not limited to: services for preventative, diagnostic, and therapeutic care, tests, counseling, and medical prescriptions for the purpose of providing care or receiving payment for said care.
- This authorization is valid for _____ following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization at any time.
- By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.
- I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

PATIENT SIGNATURE:  DATE: