Redding Gastroenterology

Paramvir Singh, MD

2110 Railroad Avenue ▪ Redding, California 96001

Phone: 530-243-1166 ▪ Fax: 877-767-4831

NAME: _____ SSN# (last 4 digits)_____

HOME PHONE: _____CELL PHONE: _____

DOB:_____ADDRESS:_____

CITY:_____STATE:_____ ZIP CODE_____

REFERRED BY:_____

EMERGENCY CONTACT PERSON: _____

PREVIOUS MD:_____

BRIEF MEDICAL HISTORY:_____

MEDICATION LIST (include vitamins & OTC)

NAME	DOSAGE	FREQUENCY

ALLERGIES: _____

_____

_____

_____

Cancel/Reschedule Policy:

You MUST cancel or reschedule within 24 hours of your appointment or there will be a cancellation fee charged to you.

Office visit fee: $50.00
Procedure fee: $100.00

PATIENT INFORMATION

(Federal regulations require a medical history must be included in all patients' medical records in this office)

Consent for Redding Gastroenterology to Use and Disclose Health Information

I,_____ , understand that as part of my healthcare Redding Gastroenterology originates and maintains paper and/or electronic 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 health 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 operations such as assessing quality and reviewing competence of healthcare professionals.

In an effort to protect your healthcare information, please list any/all names and relations of those whom we have your permission to discuss appointment dates, times, billing and medical information, (example: spouse, significant other, parents, step-parents, friends, caretaker).

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

Please provide a copy of your insurance card and photo ID when you return this questionnaire. Completion of this application does not guarantee acceptance; you will be notified upon approval.

I fully understand and accept the terms of this consent.

PATIENT SIGNATURE:_____

DATED:_____

PARENT SIGNATURE/GUARDIAN IF PATIENT IS A MINOR

_____

OFFICE USE ONLY

APPROVED BY:

DATE:

Cancellation & Missed Appointment Policy:

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner.

We would like to remind you of our office policy for missed appointments, effective August 1, 2016.

*Missed appointment for an office visit: $50 will be billed to your account.

*Missed appointment for procedure: $100 will be billed to your account.

Thank you for understanding and respecting the need for care to all of our patients.

Sincerely,

Dr. Paramvir Singh & Staff

Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____