

# Dat Tien Nguyen, M.D., Inc.

Colorectal, General & Weight Loss Surgery  
Minimally Invasive Laparoscopic Surgery

5565 W. Las Positas Blvd. Suite 360, Pleasanton, CA 94588  
Phone: 925-460-3205 or 925-460-3206 Fax: 925-460-3795

## Information Registration Form

Your name: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_  
Social security #: \_\_\_\_\_ Driver license #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_  
Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Cellular phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Today visit's problem work related?  Yes  No Date of injury: \_\_\_\_\_  
Has your employer been notified?  Yes  No

Employer name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_

How did you hear about our practice?

A doctor  A friend  Phone book  Other \_\_\_\_\_

Name of referring physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_

Emergency contact name/relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_

Spouse/parent's name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_

Spouse/parent's employer: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State/zip: \_\_\_\_\_

PRIMARY INSURANCE CO: \_\_\_\_\_ ID#: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ SSN: \_\_\_\_\_ Group#: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

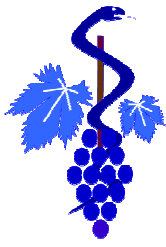
SECONDARY INSURANCE CO: \_\_\_\_\_ ID#: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ SSN: \_\_\_\_\_ Group#: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS:

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to DAT T. NGUYEN, M.D., INC. all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### Financial Policy

Thank you for choosing Dat T. Nguyen, M.D., Inc as your provider of surgical care. Our commitment is to provide high quality service. Payment for your treatment is your obligation in helping to support this commitment. To help us obtain payment for our service, all patients are required to complete the Information Registration Form before consultation with our physician.

**Without your current insurance information at the time of service, you will be treated as self-pay patient. All self-pay accounts are payable at the time of service. Co-pays are due prior to consultation with the physician. All HMO and EPO patients must have a valid referral prior to consultation with the physician. Our office accept cash, check, Visa, MasterCard.**

Regarding Insurance Coverage:

Our office accepts assignment of insurance benefits for insurance companies that we are contracted with. The detail of your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract or exactly what benefits are included or excluded in your plan. Please be aware that some, and may be all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. In the event you do not have benefits for what you were seen for, the balance of payment is you responsibility. You are also responsible to provide our office valid and up-to-date insurance information. If you provide incorrect insurance information to our office and payment is denied for any reason, you will be financially responsible for all charges.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Please check appropriate box:

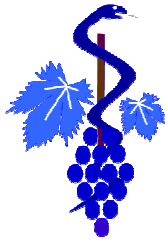
- I have a PPO plan.
- I have an HMO/ EPO plan with an authorization or a referral letter.
- I am electing to use the PPO option of my POS plan.
- The services have not been otherwise referred or authorized as required by my health plan.

I have carefully read the financial policy. I understand and agree to this financial policy.

Name of patient: \_\_\_\_\_

Responsible party: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Health Insurance Portability and Accountability Act (HIPAA)**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical or nursing students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

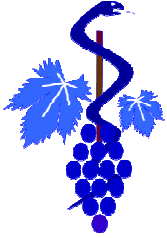
### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **August 15, 2004**  
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Your name: \_\_\_\_\_  
Your signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Medical Questionnaire

**Patient's name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Main complaint:** \_\_\_\_\_  
**Primary physician/referring physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Medical history:

Please list past and current medical illnesses: \_\_\_\_\_

\_\_\_\_\_

Please list all surgeries you have had: \_\_\_\_\_

\_\_\_\_\_

Hospitalization (reasons & dates): \_\_\_\_\_

\_\_\_\_\_

### Medications:

Current medications and dosages: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergy to medications:

Please list name of medications and types of reaction: \_\_\_\_\_

\_\_\_\_\_

### Family medical history:

Please list affected member and the medical illnesses/cancer: \_\_\_\_\_

\_\_\_\_\_

### Habits:

Do you currently smoke cigarette? \_\_\_\_\_ If no, have you ever smoked cigarette? \_\_\_\_\_

When did you quit? \_\_\_\_\_ How many do or did you smoke daily? \_\_\_\_\_

How many years have or did you smoked? \_\_\_\_\_

Do you drink alcoholic beverage? \_\_\_\_\_ How many drinks weekly and what type? \_\_\_\_\_

Have you ever used illicit or street drugs? \_\_\_\_\_ When was your last use? \_\_\_\_\_ What type? \_\_\_\_\_

### Social history:

Marital status please circle one: single/married/divorced/widow(er)

How many children do you have? \_\_\_\_\_

What city/state do you live in?: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Do you have the following conditions:**

**Skin:** Rash? No Yes  
Lump? No Yes  
Unusual change of a mole? No Yes

**Head and neck areas:**

Visual problem besides needing glasses? No Yes  
Nose infection? No Yes  
Nose bleeding? No Yes  
Sore throat? No Yes  
Swelling/lump?  
-in mouth or oral cavity? No Yes  
-in neck area? No Yes

**Cardiovascular/ heart-related:**

Short of breath:  
-at rest? No Yes  
-with activity? No Yes  
-lying flat? No Yes  
Recent chest pain? No Yes  
Past heart attack? No Yes  
Congestive heart failure? No Yes  
Heart valve disease? No Yes  
Any leg or calf pain with walking? No Yes

**Lung:**

Breathing problem? No Yes  
History of asthma? No Yes  
Any lung disease caused by smoking? No Yes  
Recurrent pneumonia? No Yes  
Recurrent bronchitis? No Yes  
Recent cough? No Yes  
Coughing blood? No Yes  
Sleep apnea? No Yes

**Gastro-intestinal:**

History of liver disease? No Yes  
History of pancreatic disease? No Yes  
Swallowing problem? No Yes  
Heart burn? No Yes  
Nausea/vomiting? No Yes  
Blood in vomit? No Yes  
Recent change in appetite? No Yes  
Abdominal bloating? No Yes  
Abdominal pain? No Yes  
Diarrhea? No Yes  
Constipation? No Yes  
Recent change in bowel habit? No Yes  
Blood in stool? No Yes

**Genitalia/Urinary:**

History kidney disease? No Yes  
History of kidney stone? No Yes  
Pain with urination? No Yes  
Blood in urine? No Yes  
Incomplete emptying of bladder? No Yes  
Frequent urination? No Yes  
Incontinence to urine? No Yes  
Female: abnormal vaginal discharge? No Yes  
Taking birth control pills? No Yes

Male: Testicle lump? No Yes

**Hematological:**

Deep venous thrombosis (clot in veins)? No Yes  
Pulmonary embolus (clot in lungs)? No Yes  
Bleeding disorders? No Yes  
History of blood transfusion? No Yes

**Endocrine:**

Diabetes? No Yes  
Thyroid diseases? No Yes  
High cholesterol or triglyceride? No Yes  
Pituitary tumor? No Yes  
Taking steroid? No Yes

**Neurological:**

History of stroke? No Yes  
Nerve problem? No Yes

**Musculo-skeletal:**

Degenerative or osteoarthritis? No Yes  
History of neck pain or problem? No Yes  
History of back pain or problem? No Yes  
Joint pain?  
- shoulder No Yes  
-hip No Yes  
-knee No Yes  
-ankle No Yes  
Muscle lump or swelling? No Yes

**Infections:**

History of bacterial resistance infection? No Yes  
History of sexually transmitted disease? No Yes  
History of HIV/ AIDS? No Yes  
History of hepatitis B or C infection? No Yes

**General:**

Fever? No Yes  
Night sweat? No Yes  
Unexpected weight loss? No Yes  
Unusually fatigue? No Yes

**Psychological:**

Depression? No Yes  
Alcohol abuse or drug addiction? No Yes  
Schizophrenia? No Yes

**Please list any other symptoms not previously listed that you have significant concern with:**

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