

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#: _____

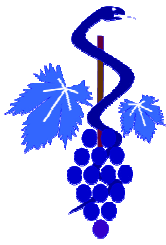
SECONDARY INSURANCE CO: _____ ID#: _____

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:

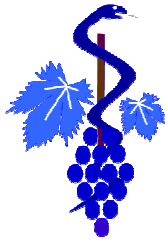
- I have a PPO plan.
- I have an HMO/ EPO plan with an authorization or a referral letter.
- I am electing to use the PPO option of my POS plan.
- The services have not been otherwise referred or authorized as required by my health plan.

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.

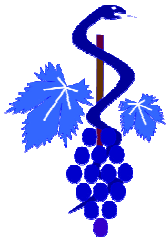
Complaints

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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Weight Loss Surgery Questionnaire

Patient's name: _____ Age: _____ Gender: male/ female (circle one)
Primary physician: _____ Referring physician: _____

History of present illness:

How long have you had problem with weight? _____

At high school graduation or at 18 years old, how much did you weight? _____

How much did you weight at 22 years old? _____

What was your age when you started to gain weight? _____

What was the cause of your weight gain? _____

What is the highest weight that you ever reached? _____

When did you reach this highest weight? _____

Please list all the diet plans and medications that you have tried and also the duration of each diet and medications: _____

Have you ever been on Fen-Phen or Redux? _____ If yes, when and for how long? _____

What was the most weight you have been able to lose? _____

When and how did you loose this weight? _____

Please describe your typical meals (what do you eat every day?):

Breakfast:

Lunch:

Dinner:

Do you snack between your meals? _____ How many snacks a day? _____

What do you snack on? _____

Do you have a craving for sweets? _____ Do you like starchy foods (potatoes, pasta or rice)? _____

Do you eat fast food? _____ If yes, what do you eat? _____

How many times a week do you eat fast foods? _____

Do you drink soda? _____ How many cans daily? _____

What do you do for exercise? _____

How much exercise each day? _____ How many times per week? _____

How long have you been contemplating gastric bypass as a way to manage weight?

Have you researched information on weight loss surgery? _____

Circle all that applied: a. researching on internet b. attending seminar c. reading brochure
d. talking to patients/ friends/ family members who had weight loss surgery

Medical history:

Please list past and current medical illnesses: _____

Do you have:

- Obstructive sleep apnea? No Yes
- Diabetes mellitus type II? No Yes
- High blood pressure? No Yes
- Heart disease? No Yes
- Degenerative joint disease/osteoarthritis? No Yes
- Gastroesophageal reflux disease/ heartburn? No Yes
- High cholesterol problem? No Yes
- Varicose veins? No Yes
- Leg ulcer due to vein disease? No Yes
- Polycystic Ovarian Syndrome? No Yes
- Nonalcoholic steatohepatitis/fatty liver? No Yes
- Pseudotumor cerebri? No Yes
- Urinary incontinence? No Yes

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 used illicit drugs? _____ What type? _____ When did you use last? _____

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:
