Dear Patient,

Your scheduled **first** appointment is the initial consultation with the doctor, which is **mandatory** and cannot be bypassed. You will **NOT** be doing any test or procedures on this day, until you have been seen, and will be provided information on that on:

DAY OF THE WEEK/DATE/TIME

Please complete the following packet and bring it in along with your **insurance card, driver's license, and medication list**, if you are taking any, on the day of your appointment. Also, take note that if you receive your packet ahead of time and it is **not** completed before your arrival, then there is a high chance that another patient will be seen ahead of you, regardless of your appointment time. If you do not receive it beforehand, then please arrive, at least, 15 minutes earlier to request it from front office and complete before you are seen by a one of our doctors. Expect a reminder call, at least one day prior to your appointment.

Contact our office for any further questions or concerns, or if you need to cancel or reschedule your appointment.

Thank you,
Staff of AGMG
Dr. Dennis Riff
Dr. Michael Demicco
Dr. Peter Winkle
Dr. Kevin Kuettel
Dr. Brian Riff

Associated Gastroenterology Medical Group
1211 W La Palma Ave suite 306
Anaheim, CA 92801

(714) 778-1300 x220 or x222 for appointment desk

Dr. Dennis S. Riff MD, FACG, CPI
Dr. Steven Duckor MD, FACG, CPI
Dr. Michael DeMicco MD, FACG
Dr. Kevin Kuettel MD
Dr. Peter Winkle MD, FACG, CPI, FACP
Dr. Brian Riff MD

ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP

1211 W. La Palma Ave
Suite 306
Anaheim, CA 92801
Phone: (714) 778-1300
Fax: (714) 778-6235

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Notes:_____

Email

Please check one as your preferred email for communications

◯ Personal:_____ ◯ Work:_____

Sex

◯ Male ◯ Female ◯ Other

Race

Select one or more

◯ White ◯ Black or African American ◯ Asian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander

◯ Unknown ◯ Patient declines to specify ◯ Prohibited by state law

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify ◯ Prohibited by state law

Preferred Language

◯ English ◯ Patient declines to specify ◯ other specify language

Contact Preference

◯ No Preference ◯ Email ◯ Telephone call ◯ Patient declines to specify

Social History

Occupation:_____ Number of Children:_____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

◯ Civil Union ◯ Unknown ◯ Other

Alcohol

◯ None

Type Number Frequency

_____

_____

Caffeine (which kind- coffee, tea, soda, energy drinks & how much?)

☐ None

Intake: _____

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Drug Use

☐ None

Type	Quantity	Number	Frequency

Exercise

☐ None

Type	Quantity	Number	Frequency

Pharmacy

Name	Address	Phone

MEDICATION LIST

NAME: _____ DOB: _____

ALLERGIES:

** Please include over the counter medications & Herbal Supplements **

CURRENT MEDICATIONS:	DOSAGE:	AMOUNT TAKEN DAILY

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Iodine-Iodine Containing
- ☐ Penicillins
- ☐ Sulfa (Sulfonamide Antibiotics)
- ☐ Latex
- ☐ Other

Immunizations

- ☐ None
- ☐ Flu vaccine When:_____
- ☐ Hep A, adult When:_____
- ☐ Hep B, adult When:_____
- ☐ Shingles Vaccine When:_____
- ☐ Pneumococcal conjugate PCV 13 When:_____
- ☐ Tetanus Toxoid When:_____
- ☐ Not at risk for TB When:_____
- ☐ At risk for TB When:_____

Diagnostic Studies/Tests

- ☐ None
- ☐ Cardiac Cath When:_____
- ☐ Cardiac Echo When:_____
- ☐ Colonoscopy When:_____
- ☐ EGD When:_____
- ☐ Exercise Treadmill Test When:_____
- ☐ Flexible Sigmoidoscopy When:_____
- ☐ Sleep Study When:_____
- ☐ Stress Test When:_____
- ☐ Stress Test with Medication When:_____

Past or Present Medical Conditions

- ☐ None

Neurological

- ☐ Anxiety When:_____
- ☐ CVA When:_____
- ☐ Depression When:_____
- ☐ Fibromyalgia When:_____
- ☐ Insomnia When:_____
- ☐ Migraine Headaches When:_____
- ☐ Neuropathy When:_____
- ☐ TIA When:_____

Cardiac

- ☐ Angina When:_____
- ☐ Arrhythmia - type unspecified When:_____
- ☐ Chest Pain When:_____
- ☐ Congestive Heart Failure When:_____
- ☐ Coronary Artery Disease When:_____
- ☐ Heart Murmur, type unspecified When:_____
- ☐ High blood pressure When:_____
- ☐ High cholesterol When:_____
- ☐ Myocardial Infarction When:_____
- ☐ Palpitations When:_____
- ☐ Shortness of Breath When:_____
- ☐ Ischemic Heart Disease When:_____

Pulmonary

- ☐ Asthma When:_____
- ☐ COPD When:_____
- ☐ Emphysema When:_____
- ☐ Sleep apnea When:_____
- ☐ Snoring When:_____
- ☐ TB exposure/ Treated When:_____

Gastrointestinal

- ☐ Anemia When:_____
- ☐ Barrett's Esophagus When:_____
- ☐ Colon Cancer When:_____
- ☐ Colon Polyps When:_____
- ☐ Constipation When:_____
- ☐ Crohn's Disease When:_____
- ☐ Diarrhea When:_____
- ☐ Erosive esophagitis When:_____
- ☐ Esophageal stricture When:_____
- ☐ Gastritis When:_____
- ☐ GERD When:_____
- ☐ Rectal Bleeding When:_____

	☐ Ulcerative Colitis When:_____			
Liver Disease	☐ Hepatitis B When:_____	☐ Hepatitis C When:_____		
Genitourinary	☐ Enlarged Prostate (BPH) When:_____	☐ Recurrent UTI When:_____	☐ Renal insufficiency When:_____	☐ Renal failure with dialysis When:_____
Endocrine	☐ Diabetes Mellitus When:_____	☐ Thyroid Disease When:_____		
Other	☐ Arthritis When:_____	☐ Cancer - Unspecified When:_____	☐ Implants When:_____	☐ Sexually Transmitted Disease When:_____
	☐ HIV When:_____	☐ Bunion When:_____	☐ Psoriasis When:_____	

Previous Procedures

☐ None

☐ Appendectomy When:_____	☐ Mastectomy R Breast When:_____	☐ C-Section When:_____	☐ Hysterectomy - Abdominal When:_____	☐ Hysterectomy - Transvaginal When:_____
☐ Back Surgery - unspecified When:_____	☐ Exploratory Laparotomy When:_____	☐ Pacemaker Insertion When:_____	☐ Cardiac Cath - intervention unspecified When:_____	☐ Defibrillator Placement When:_____
☐ Cataract Surgery When:_____	☐ Hiatal Hernia Repair When:_____	☐ Hernia Repair - site unspecified When:_____	☐ Gastric Bypass - type unspecified When:_____	☐ Anal Fissure Repair When:_____
☐ Prostate Biopsy When:_____	☐ Tonsillectomy When:_____	☐ Cholecystectomy - Laparoscopic When:_____	☐ Other When:_____	

Family Medical History

☐ No knowledge of family history

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather	Aunt	Uncle
Diabetes mellitus	○	○	○	○	○	○	○	○
Family History of Colon Cancer	○	○	○	○	○	○	○	○
Family History of Colon Polyps	○	○	○	○	○	○	○	○
CA - Stomach	○	○	○	○	○	○	○	○
CA - Pancreatic	○	○	○	○	○	○	○	○
CA - Unspecified	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○	○
Celiac Sprue	○	○	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

○ None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

○ None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

○ None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

○ None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

○ None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Gastrointestinal

○ None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

○ None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

○ None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

○ None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

○ None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

○ None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

○ None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Associated Gastroenterology Medical Group

Patient Demographic Information Form

NAME (FIRST, MIDDLE INITIAL, LAST)		**SOCIAL SECURITY #:** - -
ADDRESS (include unit/apt#, city, state, zip code)		**Marital Status (circle one)** Single married divorced widowed
Birthdate	**Referring Doctor:**	
Home Phone #	**Cell Phone #**	**Work Phone #**
_ Ok to leave call back number only.	**_ Ok to leave call back number only.**	**_ Ok to leave call back number only.**
_Ok to leave detailed message with person.	**_Ok to leave detailed message.**	**_Ok to leave detailed message with person.**
_Ok to leave detailed messaged on answering machine.		**_Ok to leave detailed message with personal voicemail.**
Emergency Contact: (Name/Relation/Phone number)		
Email Address:		

I hereby authorize all insurance benefits to be paid directly to ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP. I understand that I am responsible for charges as designated by my insurance companies (e.g. deductibles, copayments). I am also responsible for all charges not covered by my insurance and for any finance fees incurred on unpaid balances. I authorize ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP to release any information to my insurance companies whenever requested by them.

_____ X_____

DATE SIGNATURE

(Flip to next page) → 7

ASSOCIATED GASTROENTOROLOGY MEDICAL GROUP

INSURANCE WAIVER FORM

Our staff is here to provide you with the best medical care possible. Due to the changes in medical industry, it has been brought to our attention that, at times, many insurance companies inlcuding Health Maintenance Orangizations (HMO) and Preferred Provider Organizations (PPO) are unwilling to pay for medical services we feel is necessary.

We will do our utmost to comply with the needs of your insurance company, such as, obtaining pre-authorizations, pre-certifications, verifications of insurance benefits, deductibles, and/or co-payments. However, regardless of how compliant we are, the above procedures do not always guarantee payment. If there is a case when your insurance company does not pay for any services rendered in our office, you are authorizing by signing this form to have the services directly billed to you. Should this become necessary, please contact our office, and we will gladly assist you in making payment arrangements.

If you have any questions as to which services are covered by your insurance, please contact them directly or read your insurance policy manual.

Sincerely,

AGMG Staff
Dr. Dennis S. Riff, M.D., FACG, Inc.
Dr. Michael P. DeMicco, M.D., FACG, Inc.
Dr. Steven L. Duckor, M.D., FACG, Inc.
Dr. Peter J. Winkle, M.D., FACG, CPI
Dr. Kevin D. Kuettel, M.D.
Dr. Brian P. Riff, M.D.

PRINT NAME/SIGN DATE

(2)

ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP
1211 W LA PALMA AVE SUITE 306
ANAHEIM, CA 92801
Tel #: (714) 778-1300

ADVANCED DIRECTIVES

ADVANCE DIRECTIVES ARE WRITTEN INSTRUCTIONS, WHICH COMMUNICATE YOUR WISHES ABOUT THE CARE AND TREATMENT YOU WANT, IF YOU REACH A POINT WHERE YOU CAN NO LONGER MAKE YOUR OWN HEALTHCARE DECISIONS. THIS DOCUMENT INCLUDES NAME OF PERSON THAT IS AUTHORIZED TO MAKE NECESSARY DECISIONS AS WELL.

I HAVE EXECUTED AN ADVANCED DIRECT: YES NO

(CIRCLE ONE)

I HAVE DISCUSSED THIS ADVANCED DIRECTIVE WITH MY PHYSICIAN BEFORE:

YES NO

(CIRCLE ONE)

_____

PRINT NAME/SIGNATURE DATE

ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP

HIPAA Notice of Privacy Practices

Associated Gastroenterology Medical Group
1211 W. La Palma Ave. #306
Anaheim, CA 92801
714-778-1300

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.

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 the 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 **April 14, 2003.**

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:

Print Name:_____ Signature_____ Date_____

ASSOCIATED
GASTROENTEROLOGY
MEDICAL
GROUP

Dennis S. Riff, M.D.,
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(714) 778-1300 ☐
Fax: (714) 778-6235 ☐

2617 East Chapman Avenue
Suite 302
Orange, CA 92869
(714) 633-1823 ☐
Fax: (714) 633-1615 ☐

AGMG ENDOSCOPY CENTER
PATIENT PORTAL: FREQUENTLY ASKED QUESTIONS

1. What do I need to set-up and access my Patient Portal?
All you need is access to a computer, tablet, laptop or Smartphone, an internet connection, and an email account.

2. When can I sign-in to my Patient Portal?
You have access to your Patient Portal 24 hours a day, seven days a week. Information about your visit will be available within 24 hours of your discharge.

3. Is my Patient Portal secure?
Your Patient Portal uses a secure, encrypted connection that meets the highest industry standards. Your personal and medical information in your Patient Portal is confidential.

Only you and those persons you authorize are able to gain access to the information in your Patient Portal. We will not share or release your information.

4. Are you going to send me emails?
You will receive one email notification inviting you to create your Patient Portal account. In the future, you may receive health care reminders via your Patient Portal.

5. Can I give my authorized representative (e.g. spouse, caregiver) access to my Patient Portal?
Yes. Anyone who is at least 18 years of age can be your authorized representative.

6. If I need to correct or update my personal information (name, address, and telephone number) can I do this via my Patient Portal?
Yes. You may email our office via your Patient Portal with your updated information. This information will be updated within 24-48 hours.

7. Can I request my medical records via my Patient Portal?
The recommended way to request copies of your medical records is to complete an **Authorization for Release of Health Information** form.

Please contact our office at 714-778-1300 for additional information on obtaining a copy of your medical records.

For additional questions about your Patient Portal, please call or email our Electronic Medical Records Department at 714-778-1300, Ext. 266, or saltamirano@agmg.com.

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ASSOCIATED GASTROENTEROLOGY MEDICAL GROUP
http://www.agmg.com/

About the Patient Portal
We invite you to join the Patient Portal by registering online today. Our Patient Portal is a free, secure online service that gives you 24/7 access to information about your recent visit.

Register for the Patient Portal to:

- View your health summary
- View your prescribed medications
- View information about follow-up care
- Communicate with our staff regarding your care

Our Patient Portal allows you to be more actively involved in your health care. We provide a safe and secure way for you to communicate with your care team and with your physician. This will help you make more informed decisions about your care.

Only you and those whom you authorize will be able to view your information on the Patient Portal, and your health care team will not share or release your personal information.

To register for the Patient Portal follow the simple steps below:

1. Provide your preferred email address to receive an invitation to register (You may do this in person or by calling our office at 714-778-1300).

2. Visit us at http://www.agmg.com/ and **Contact Us** to request an invitation to register. You will be provided with a temporary PIN, which will be sent to the email address you provide.

3. With the temporary PIN we provide, you will be able to register via the **Patient Portal** from our website: http://www.agmg.com/

If you have any questions about registration for the Patient Portal, please call or email the Electronic Medical Records Department at 714-778-1300, Ext. 266, or saltamirano@agmg.com