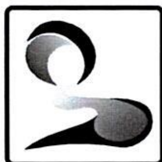

Kern Gastroenterology Medical Group

5959 Truxtun Avenue, Suite 200, Bakersfield, CA 93309 ◆ (661) 324-1203 ◆ Fax: (661) 324-3195

Patient Update Information

Date: ________________

Patient name: ____________________________________ DOB: _________________

SS#: _________________________ Telephone #: __________ Cell phone #: ____________

Address: ____ City: ___________________

State: ________________ ZIP: ___________________

Email address: ____

Emergency Name and Phone Number: ____

Primary Insurance:

Insurance: ____________________________________ Group No: ___________________

Secondary Insurance:

Insurance: ____________________________________ Group No: ___________________

Primary Care Physician: _________________________________ Phone: ______________

Address: ____ City: ___________________

State: ________________ ZIP: ___________________

Kern Gastroenterology Medical Group

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HEALTH QUESTIONAIRE

Date: ________________ Referring Doctor: ________________________

Patient name: ____________________________________ DOB: ________________

Email address: ____

List all Medications you are taking

____
____
____
____
____
____

Allergies

____
____
____
____
____
____

Has your Health changed since your last visit: **Yes** **No** (*If yes, please explain below*)?

____
____
____

Have you had any surgeries since your last visit: **Yes** **No?**

If yes, please list surgical procedure and date it was done:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Kern Gastroenterology Medical Group

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Acknowledgement and Patient Preferences
Designee to Receive information

Patient name: ______________________________ DOB: ______________

HIPPA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit disclosure of protected health information (PHI). PHI is any data concerning your treatment in the office. We make every effort to comply completely with these HIPPA privacy regulations. At the same time, we do not want our patients to be inconvenienced when they wish to have a spouse of family member call us for healthcare information pertaining to you from our office when it is inconvenient for you to do so.

Please list designee recipients who can obtain this information:

______________________________ ______________________________
Name of Designee to Receive Protected Health Information Relationship to patient

______________________________ ______________________________
Name of Designee to Receive Protected Health Information Relationship to patient

______________________________ ______________________________
Name of Designee to Receive Protected Health Information Relationship to patient

______________________________ ______________________________
Name of Designee to Receive Protected Health Information Relationship to patient

______________________________ ______________________________
Patient signature Date