Euclid Endoscopy Center, LP
286 Euclid Ave Suite 109 San Diego, CA 92114
PH# 619-564-8249 FAX 619-564-8236

Last Name: ______________________ First Name: _____________ DOB :__________ Sex: M F

Adress:________________________________ City:______________ Zip:________________

Home Phone:(__)____________________ Married___Single___Separated___Widowed___

Ethnic Backgroud:____________________ Driver's License#:______________________________

Social Security# (Required):____________________________

Patient Employed By: ________________________________ Work hone#:________________

Work Adress:______________________________ City:____________ Zip:_________________

Primary Care Physician: __________________________ **Referred By:**_____________________

Emergency

Contact:______________________ **Relationship:**______________ **Phone:**__________________

Adress:___________________________________ City:_____________ Zip:_________________

INSURANCE INFORMATION (REQUIRED)

Primary Coverage, Name of Carrier:

____

Group No.____________________

ID Number:___________________

Subscriber:___________________

Effective Date:________________

Secondary Coverage, Name of carrier:

____

Group No.____________________

ID Number:___________________

Subscriber:___________________

Effective Date:________________

Are you covered by Medicare? Yes___ No___

Are you covered by Medi-Cal? Yes___ No___

Medicare No.__________________________

Medi-Cal No.__________________________

Issue Date:___________________________

We ask all patients to show their insurance or manage care membership card at the time of service, so that we may make copies of them. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will cret any such collections to the patient's account.

Payment Authorization:

I,____________________, hereby authorize, Euclid Endoscopy Center LP, to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of this authorization will be valid as the original.

Signature of Patient:__________________________________ Date:____________________

DO YOU CURRENTLY HAVE AN ADVANCE DIRECTIVE? ☐YES ☐NO

WOULD YOU LIKE INFORMATION ON ADVANCE DIRECTIVES ☐YES ☐NO

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San Diego, CA 92114

EEC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility, on our website, and have copies available for distribution.

I,________________________________, have received or read the copy of this facility's Notice of Privacy Practices.

Signature:____ Date:________________________

Listed below are the authorized individuals to be a receiver of directory information for the purposes of transportation post operatively as well as possible other contacts the patient may receive while he/she is receiving services at this facility. Any attempts at contact from individuals not listed below will be re-directed in accordance with privacy practices.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but the acknowledgment could not be obtained because:____

*** TO OUR PATIENTS ***

The California Health and Safety Code (Section 12837) requires that we collect and submit the following information to the Office of Statewide Health Planning & Development beginning January 1, 2005 We have all the information except 'Race' and 'Ethnicity'.
For text of the law, visit the California Legislative Information website at www.leginfo.ca.gov

Please mark 1 box in each section below. Thank You.

Race

- American Indian or Alaska Native (R1)
- Asian (R2)
- Black/African American (R3)
- Native Hawaiian/Pacific Islander (R4)
- White (R5)
- Other Race (R9)
- Unknown (99)

Ethnicity

- Hispanic/Latino (E1)
- Non-Hispanic/Latino (E2)
- Unknown

Principle Language Spoken

ENG English	JPN Japanese
ARA Arabic	NAV Navajo
ARM Armenian	PER Persian
KHM Cambodian	POL Polish
CHI Chinese	POR Portuguese
SCR Croatian	RUS Russian
FRE French	SCR Serbian
CPF French Creole	SPA Spanish
GER German	TGL Tagalog
GRE Greek	THA Thai
GUJ Gujarathi	URD Urdu
HEB Hebrew	VIE Vietnamese
HMN Hmong	YID Yiddish
HUN Hungarian	Unknown
ITA Italian	

☐Individual refused to sign
☐Communication barriers prohibited obtaining acknowledgment
☐An emergency situation prevented us from obtaining acknowledgment
☐Other (Please Specify)____

Southern California Gastroenterology
Anesthesia Specialists

Endoscopy Center____

Request for Administration of Anesthesia

Consent for Anesthesia Services

I authorize the Anesthesia Provider, ____ to provide anesthesia services as part of my upcoming surgery or procedure.

I understand and agree that the primary method of anesthesia administration will be deep sedation. This method has been discussed with me in terms that I can understand. If, in the course of treatment, conditions dictate a change in method, I understand and agree that this will be done at the discretion of the Anesthesia Provider in attendance.

Additionally, I authorize the performance of any other procedures that in the judgment of the Anesthesia Provider may be necessary for my well-being, including such interventions as are considered medically advisable to remedy conditions discovered during the surgery or procedure.

I am satisfied with my understanding of the nature of the anesthesia plan of care and the more common drawbacks and complications associated with it. These may include, but are not limited to: swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma, including fracture or loss of teeth, bridgework, dentures, dental implants, crowns and fillings, and laceration of the gums or lips; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulties breathing, permanent organ damage, cardiac arrest and death.

No warranty or guarantee has been made as to the outcome of the anesthesia plan of care,

I have been given the opportunity to ask questions about the anesthesia. I have been given explanation of procedures and techniques that may be used, as well as the risks, benefits and alternatives. I understand that there are risks with any surgery or procedure and anesthesia, and it is impossible for the physician to inform me of every possible complication. I believe that I have sufficient information to give this informed consent.

The undersigned certifies that he/she has read the foregoing, and the patient, the patient's legal guardian, or the patient's authorized representative accepts its terms.

______________________________________ ______________________________

Patient Signature Date / Time

Anesthesia Provider Statement

I certify that I have explained to the patient/responsible adult the risks, benefits and alternatives of the anesthesia and have allowed the patient/ responsible adult to ask questions.

______________________________________ ______________________________

Anesthesiologist Signature or
Certified Registered Nurse Anesthetist Signature

Date/ Time