GANG QUAN MD

3313 UNICORN LAKE BLVD SUITE 152
DENTON, TEXAS 76210

Last Name ____________________ First Name ____________________

Date of Birth ____________________ Social Security # ____________________ ☐ Male ☐ Female

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Number ____________________ Work Number ____________________ Cell Number ____________________

Street Address ____________________

City / State / Zip Code ____________________

Mailing Address ____________________

City / State / Zip Code ____________________

Person to call in case of an emergency ____________________ Phone Number ____________________

Family Doctor Name ____________________ Phone Number ____________________

Pharmacy Name ____________________ Phone Number ____________________

How did you hear about us? (Referring Doctor, Phone Book, Internet, Hospital, etc) ____________________

____
Patient Last Name

Do you have any Allergies to any Medications? ☐ **YES** ☐ **NO** **(If yes, please list below)**

____

____

Please list ANY Medications you take on a regular basis. Make sure to include any vitamins or supplements.

☐ **See List**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Medical History

☐ Congestive Heart Failure
☐ Hepatitis A, B, C,
Type? ______
☐ High Blood Pressure
☐ Diabetes
☐ Iron Deficiency Anemia
☐ Colon Cancer
☐ Colon Polyps
☐ COPD
☐ Asthma
☐ Coronary Artery Disease
☐ High Cholesterol
☐ High Triglycerides
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________

Surgical Surgery

☐ Appendectomy
☐ Colon Resection
☐ Hernia Repair
☐ Hysterectomy
☐ Adenoidectomy
☐ C-Section
☐ Gallbladder Removal
☐ Tonsillectomy
☐ Pacemaker / ICD Implant
☐ ____________________
☐ ____________________
☐ ____________________
☐ ____________________

Family Medical History

☐ Alcoholism
☐ COPD
☐ Gallstones
☐ Depression
☐ Diabetes
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hypertension
☐ Asthma
☐ ____________________
☐ ____________________
☐ ____________________

Has anyone in your family ever had Colon Cancer?
☐ Yes ☐ No

Who? ____________________
____

____
Patient Last Name

Tobacco

☐ Non Smoker
☐ Current Use
How many per day? _________
☐ Quit _____________
☐ Smokeless Tobacco

Alcohol

☐ Non Drinker
☐ Rare Use
☐ Social Use
☐ Regular Use
☐ Current Alcoholic

Illicit Drugs

☐ Never Used
☐ Experimented With
☐ Current User
☐ Marijuana
☐ Cocaine
☐ Meth / ICE / Speed
☐ Heroin
☐ Prescription Abuse

CURRENT PROBLEMS

Constitutional

☐ Chills
☐ Fatigue / Tired
☐ Unexplained Fever
☐ Night Sweats
☐ Weight Loss
☐ Weight Gain

Cardiovascular

☐ Chest Pain
☐ Dizziness
☐ Irregular Heartbeat
☐ Swelling in Feet and Ankles
☐ Tachycardia
☐ Weight Gain

Respiratory

☐ Chronic Cough
☐ Shortness of Breath
☐ Coughing up blood
☐ Wheezing

Gastrointestinal

☐ Abdominal Pain
☐ Acid Reflux
☐ Loss of appetite
☐ Bloating
☐ Difficulty Swallowing
☐ Constipation
☐ Diarrhea
☐ Heartburn / GERD
☐ Hemorrhoids
☐ Dark, Tarry stools
☐ Nausea
☐ Vomiting
☐ Rectal Bleeding

Psychiatric

☐ Anxiety
☐ Bi-Polar
☐ Depression
☐ Feeling Stressed
☐ Personality Change
☐ Mood Swings
☐ PMS
☐ Poor Concentration
☐ Sleep Disturbance
☐ Suicidal Thoughts

How much do you weigh? _______________

How tall are you? ______________

Patient Consent

In the course of providing care to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you and in order to obtain payment for our services.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. We are able to refer to this Notice at any time. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided in our office, but also disclosures for your health information may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your information for purposes of payments includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third party payers or insurers for claims review, determination of benefits and payments; our submission of your health information to auditors hired by third party payers and insurer, among other aspects or payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy policies change. You can receive an updated copy from our Office Administrator.

By signing this consent, you signify that you agree that all payment's are deemed your responsibility and are due at the time of service, unless prior arrangements have been made, or you have insurance coverage in which you have provided copies of for filing purposes.

My signature on this form will serve as "SIGNATURE ON FILE" for processing any applicable insurance claims. I understand that my insurance may deny benefits if determined I received an examination too frequently or received examinations by separate doctors for the same illness. I agree to pay for services that my insurance deems my responsibility.

I agree to pay my co-pay, co-insurance, and or deductible at the time services are rendered. I also understand that all costs are estimates and that the insurance will make the final determination in the amount that I am responsible for.

By signing this consent, you signify that you agree that we can, will use, and disclose your health information to treat you and to obtain payment for our services rendered to you.
We may decline treatment should you refuse to sign this consent.

_______________________________________ _____________________

Patient Name (printed) DOB

____________________________________ _____________________

Patient / Legal Guardian Signature Date

_______________________________________ _____________________

Witness / Office Staff Signature Date