CAREY B. STROM, M.D.
9090 Wilshire Blvd Ste. 101, Beverly Hills, CA 90211

Account No.		Date

Patient Registration

Personal Information

Patient Name (Last, First, MI)	Address
Social Security#	City, State / Zip Code
Date of Birth / Age / Sex M F	Home Phone / Cell Phone
Martial Status Single Married Other	E-Mail Address
Primary Language	Your Regular Physician / Phone No.
Ethnicity / Race / Religion	Referring Physician / Phone No.

Employment Information

Employment Status (Circle One)

Full Time Part Time Self Employment Not Employed Retired (Date) Student

Name of Employer/Union/Guild	Occupation
Employer Address	Employer City, State, ZIP

Additional Information

Driver's License State/ID	Mother's Maiden Name	Place of Birth City & State	Pharmacy
Driver License ID#/ID#	Patient's Maiden Name		Pharmacy Phone & Fax#

Emergency Contact

Name	Relationship	Home Phone	Work Phone
Address, City	State, Zip Code	Legal Guardian Yes No	Cell Phone

Guarantor Information

Name of Person who is Financially Responsible for the Patient		Relation to Patient
Employer	Social Security Number	Date of Birth

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Insurance Information

Primary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Primary Insurance Claim Address

Secondary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Secondary Insurance Claim Address

Third Party Billing (Or Remarks)

Street Address	City, State	Zip Code

- AUTHORIZATION TO PAY -

I hereby authorize my insurance provider to pay the physician responsible for my care directly. **I understand that Jonathan C. Ellis, M.D. and Carey B. Strom, M.D. are not contracted providers of any insurance policies other than Medicare, but as a courtesy will bill my insurance for the out of network benefits where applicable** and authorize the release of my medical records to my third party payer in order to obtain payment. I fully understand that my insurance may not cover all of the charges and that I am responsible for payment of my account. In the event that my insurance policy issues payment to me, I agree to forward full payment to the rendering physician immediately. I further understand that in the event that my account remains unpaid after 120 days it will be subject to a 6% interest charge.

SIGNATURE: ______________________________ DATE: ________________

TOWER DIGESTIVE HEALTH MEDICAL GROUP
CAREY STROM, MD, FASGE

HEALTH HISTORY QUESTIONNAIRE – GASTROENTEROLOGY

Patient Name: ______________________________
MRN: ____________________
Date of Appointment: _______/_______/_______(mm/dd/yyyy)

Please fill this form out as completely as possible and bring it to your appointment.

PAST MEDICAL HISTORY – *place a checkmark in the box next to any medical problems you have had in the past*

Anemia		Diabetes		Kidney Disease	
Anxiety/Depression		Diverticulitis		Lactose Intolerance	
Barrett's Esophagus		Heart Disease		Liver Disease	
Bleeding Disorder		Heartburn/Ulcers		Lung Disease	
Bowel Obstruction		Hemorrhoids		Pancreatitis	
Cancer		Hepatitis A		Sleep Apnea	
Type:		Hepatitis B		Stroke	
Celiac		Hepatitis C		Thyroid Disease	
Cirrhosis		High Blood Pressure		Ulcerative Colitis	
Colon Polyps		Irritable Bowel Syndrome		Other (please specify below)	
Crohn's Disease					

PAST SURGICAL HISTORY – *place a checkmark in the box next to any surgeries you have had and the date of surgery if you know it*

Appendectomy		Colonoscopy		Obesity Surgery	
Bowel Resection		Coronary Artery Surgery		Stomach Surgery	
Breast Surgery		Gallbladder Surgery		Other (please specify below)	
Colon Surgery		Heart Surgery			

IMMUNIZATIONS: If yes, give the approximate year given

- ☐ Pneumococcal Date________________
- ☐ Hepatitis A Date________________
- ☐ Hepatitis B Date________________
- ☐ Tetanus Date________________

Have you ever had a colonoscopy?

☐ Yes ☐ No Date_____________
Findings____

Have you ever had an upper endoscopy?

☐ Yes ☐ No Date_____________
Findings____

ALLERGIES

Do you have any allergies to medications, Latex, or foods? If yes, please list them below.

MEDICATIONS – *Please list any medication(s) you currently take, including over-the-counter medications*

Name	**Dose** (mg, number of tablets, etc)	**How often** (once a day, twice a day, only as needed, etc)

Pharmacy Name and Address ____

FAMILY HISTORY – *place a checkmark to report problems your family members have had. Please state the age when they had the problem, if you know it.*

☐ I was adopted, so I do not know my family history.

	Mother	Father	Sister	Brother	Son	Daughter	Other
Alive?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	
Barrett's Esophagus							
Bleeding Problem							
Celiac Disease							
Colon Cancer							
Colon Polyps							
Crohn's Disease							
Diabetes							
Esophageal Problems							
Esophageal Cancer							
HIV/AIDS							
Hemorrhoids							
H-Pylori							
Irritable Bowel Disease							
Lactose Intolerance							
Liver Disease							
Pancreas Disease							
Psychiatric Disease							
Stomach Cancer							
Reflux							
Ulcerative Colitis							

SOCIAL HISTORY

Tobacco Use

- ☐ Never smoked
- ☐ Former smoker
- ☐ Every day smoker
- ☐ Heavy smoker
- ☐ Light smoker
- ☐ Passive smoke exposure – secondhand smoke

Alcohol Use

Do you ever drink alcohol? Yes / No

If yes, please indicate the quantity per week: ______________________________

Drug Use

Do you use recreational drugs? Yes / No

If yes, please indicate what type: