Won Jo, M.D.

Gastroenterology and Hepatology

PATIENT REGISTRATION FORM

APPOINTMENT DATE: _____ **TIME:** _____

NAME: _____

DATE OF BIRTH: _____ **AGE** _____

SOCIAL SECURITY NUMBER: _____

GENDER: **(Please circle one)** **MALE** **FEMALE**

OCCUPATION: _____

HOME ADDRESS: _____

CITY: _____ **ZIP:** _____

PHONE NUMBERS:

Home _____ **[ ] OK to leave detailed message**

Cell _____ **[ ] OK to leave detailed message**

Work _____ **[ ] OK to leave detailed message**

EMERGENCY CONTACT INFO: **(Please list name, phone number and relationship)**

_____

PRIMARY CARE PHYSICIAN: _____

Please notify us at least one week in advance if you need to cancel or reschedule your appointment.

Please don't forget to bring your insurance card. We only accept cash or check as payment.

Please be aware that you may be held responsible for reasonable attorney fees, court costs, collections costs and interest at 1.5% per month if your account becomes delinquent.

Patient Signature: _____ **Date:** _____

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Name: _____ **Date:** _____

Reason for visit (ie, symptoms):

_____

Do you have any medical problems? (ie, diabetes, high blood pressure, etc…)

_____

_____

_____

_____

Have you had any surgeries, including colonoscopy and upper endoscopy, in the past? If so, when?

_____

_____

What medications are you currently taking?

_____

_____

_____

_____

Please list any allergies to medications: _____ ☐ No allergies

Do you smoke? ☐ No ☐ Yes How much and how often? _____

Do you drink? ☐ No ☐ Yes How much and how often? _____

Is there a family history of colon cancer? ☐ No ☐ Yes If so, who and what age were they diagnosed?

_____

_____

Is there anything else you would like us to know about?

_____

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