Won Jo, M.D.

Gastroenterology and Hepatology

PATIENT REGISTRATION FORM

APPOINTMENT DATE: _____ **TIME:** _____

NAME: _____

DATE OF BIRTH: _____ **AGE** _____

SOCIAL SECURITY NUMBER: _____

GENDER: (Please circle) MALE FEMALE OTHER _____

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:** _____

424 E. Vanderbilt Way, Suite B • San Bernardino, CA 92408 • Office: (909) 796-0363 • Fax: (909) 255-7292 • www.wonjomd.com

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Name: _____ **Date:** _____

Reason for visit:

_____

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

_____

_____

_____

_____

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

_____

_____

Please list the names of the medications you are currently taking:

_____

_____

_____

_____

Please list any allergies to medications: _____ ☐ No allergies

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

Do you use marijuana? ☐ No ☐ Yes For how long and how often? _____

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

Have any family members been diagnosed with cancer of the esophagus, stomach, liver, pancreas or colon? ☐ 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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