GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.

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DATE: _____ NAME: _____

REFERRED BY DR. _____

CURRENT PROBLEM: Please describe the reason for your visit (include your most bothersome symtoms, its duration, etc)

_____

_____

PAST HISTORY:

List surgery, with dates

1. _____
2. _____
3. _____
4. _____
5. _____

List serious illnesses, with dates

1. _____
2. _____
3. _____

List your medications

1. _____
2. _____
3. _____

Allergies/Reactions to medications

1. _____
2. _____
3. _____

GENERAL (circle)

Blood Transfusion	Y	N
Recent travel outside USA	Y	N
Heart Murmur	Y	N
Do you take antibiotics for dental procedures	Y	N

Date of last Chest Xray _____

(WOMEN)

Date of last menstrual period _____

FAMILY HISTORY (Circle if appropriate)

Ulcers
Gallbladder Disease
Cancer What type? _____
High Blood Pressure
Heart Disease
Diabetes

SOCIAL HISTORY

Your age	_____	Marital Status	_____
Children	_____	Ages	_____, _____, _____
Smoke	_____	How much	_____
Alcohol	_____	How much	_____
Coffee	_____	How much	_____
Aspirin	_____	How much	_____
Arthritus pills	_____	How much	_____

REVIEW OF SYSTEMS

(Circle if applies to you)

heartburn	heart disease
indigestion	lung disease
weight loss	night sweats
appetite loss	thyroid disease
trouble swallowing	sexual problems
diarrhea	psychiatric problems
constipation	skin problems
liver disease	headaches
jaundice	chest pain
high blood pressure	arthritis
gallbladder trouble	kidney disease
vomiting blood	bladder infections
rectal bleeding	irregular periods
colitis	convulsions
diverticulitis	

GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.
PATIENT REGISTRATION

Date: _____

NAME: _____
(Last) (First) (Middle)

ADDRESS: _____
(Number) (Street) (Apt #)

_____
(City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birth Date: _____ Sex: _____ Marital Status: _____ Cell Phone: _____

Employer: _____ Name/Address: _____

Social Security #: _____ Referred by: _____

FINANCIALLY RESPONSIBLE PERSON/INSURANCE SUBSCRIBER

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Name/Address: _____

Social Security #: _____

Birth Date: _____

Other person to notify in emergency _____ Phone: _____

INSURANCE INFORMATION

Name of Primary Insurance Co.	Policy #	Group #/Name	Policy Holder Name	Policy Holder D.O.B.
Ins. Address		Social Security #	Employer	
Name of Secondary Insurance Co.	Policy #	Group #/Name	Policy Holder Name	Policy Holder D.O.B.
Ins. Address		Social Security #	Employer	
Name of Other Insurance	Policy #	Group #/Name	Policy Holder Name	Policy Holder D.O.B.
Ins. Address		Social Security #	Employer	

PATIENT AUTHORIZATION FORM

I, _____, hereby authorize Gastroenterology Center of Northern Virginia, LTD, to apply for benefits on my behalf for covered services rendered and request that the payments from the insurance company(s) listed above be made directly to Gastroenterology Center of Northern Virginia, LTD.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of necessary information including medical information for this or any related claim to the insurance company(s) listed above or in case of Medicare Part B Benefits, to me or the party who accepts assignments. If a patient's account is sent to collections, they will be responsible for all attorney and/or collection fees associated with the account.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

_____
Signature of Patient or authorized person

WE WILL NEED TO COPY YOUR INSURANCE CARDS FOR YOUR CHART
THANK YOU

Gastroenterology Center of Northern Virginia, Ltd

www.gcofnova.com

PATIENT OFFICE POLICY NOTICE

INSURANCE REFERRALS: Please have necessary referral forms with you at the time of your appointment if required by your insurance. This applies to HMO and managed care plans. Please arrange this in advance with your primary care doctor.

INSURANCE CO-PAY'S: Please be prepared to pay your co-pay at the time of service. If you are unsure of the amount due, please obtain that information prior to your appointment. We accept exact cash or credit cards (Visa and MasterCard.)

TARDINESS: We make every attempt to see you close to your appointment time. The doctors do however sometimes run late due to the nature of specialty practice. Please call if you are running late. If you arrive more than 15 minutes late for your appointment we will see you if at all possible, but it may be necessary to reschedule your appointment. Have all records and paperwork ready for your visit with the doctor.

MISSED APPOINTMENTS: There will be a $30.00 charge for office appointments missed or canceled with less than 24 hours notice. Allow us to offer an open appointment to other patients waiting. Your understanding is appreciated.

PROCEDURE APPOINTMENTS: There is $150 charge for canceling with less than 5 business days advance notice. This charge is the responsibility of the patient and must be paid before rescheduling your procedure. Again, thank you for allowing another patient waiting to take an open appointment.

MEDICAL RECORDS/FORMS: There is a fee for copying or faxing your complete medical record. Please keep copies of any records you give us for your personal file. We do not provide copies of other doctor's records to you. Each healthcare provider is responsible to give those to you directly. There is a $25.00 fee for completing forms, disability applications, dictated letters requested, etc.

PRESCRIPTIONS: Written prescriptions will be provided at your office appointment. If you require a 90 day supply for mail order, please ask the doctor **at the time of your appointment.** Replacement or lost prescriptions must be picked up at the office. Insurance authorization, (if required) for medications can take up to a week. To expedite the process be sure you have provided current insurance and prescription card information. We sometimes need to change medications to coincide with your plans preferred medications. We do not call or fax prescriptions to **Mail Order** pharmacies. Please give at least 4 days notice on local refills.

SIGNATURE _____ Date: _____/____/_____

I am aware of the patient office policies of Gastroenterology Center of No. VA and have received a copy.

GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.
Privacy Information and Disclosure Agreement

1. Please provide a **Phone Number** at which a **Private message** (to include test results) may be left for you: _____

2. Provide a personal and private email address: _____

- o **CHECK HERE IF YOU DO NOT WANT MESSAGES LEFT FOR YOU.**

3. List the name(s) of anyone you allow disclosure of personal information to include scheduling, confirming of appointments and test results. Specify information to be disclosed or you may say "ALL."

NAME	RELATIONSHIP	ALLOWED DISCLOSURE

I hereby acknowledge that I am aware of Gastroenterology Center of Northern Virginia, LTD's Notice of Privacy Practices (HIPAA), and that a copy of the policy is available to me upon request. I also acknowledge that this release to the above persons is in effect until I revoke it in writing.

_____
PRINT PATIENT'S NAME

_____
SIGNATURE (Required)

_____
DATE

Gastroenterology Center of Northern Virginia, Ltd.

www.gcofnova.com

Please provide your complete pharmacy information. Provide a local pharmacy and the name of your mail order (if you have one) to be used at a future date in our upcoming electronic medical records.

Patient Name_____

Date of Birth_____

Pharmacy Name _____

Store Number_____

Location/Address_____

Pharmacy Number_____

Pharmacy Fax_____

Mail order pharmacy used_____