THE CENTER FOR GASTROINTESTIONAL HEALTH
601 Old Wagner Road Petersburg, VA 23805
Tele: 804-835-9398 Fax: 804-414-7062

PATIENT REGISTRATION AND INTAKE FORM

Name: _____ **Date of Birth:** ____/____/_____ **SS:** ___-___-_____

Mobile Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Address: _____

City, State, Zip _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone Number(s): _____

_____ Single _____ Married _____ Divorced _____ Widowed _____ Domestic Partnership

What is the reason for this visit, and who is the physician or provider sending you to our office?

_____

Who is your Primary Care Physician?

Name: _____ Telephone: _____

Address: _____

What pharmacy do you use?

Name: _____ Telephone: _____

Address: _____

TELL US ABOUT YOURSELF:

TB Screening:
- ☐ Night sweats
- ☐ Weight Loos
- ☐ Coughing up blood
- ☐ Fever
- ☐ Loss of appetite

Do you smoke? No___ Yes___
If yes, how many packs a day? _____
If you have quit, how long ago? _____

Do you use alcohol? No__ Yes__
If yes, how often do you drink? _____
If you have quit, how long ago? _____

PAST MEDICAL HISTORY:

Please list other diseases/medical conditions from which **you** currently or previously suffer (heart, lung, etc.):

Please list any surgeries (operations) **you** have received, reason for the surgery, and date of surgery:

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric								
Genetic (inherited) disorder								
Other								

☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: If YES, give approximate year given

Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____

Transfusions:

Have you ever received a blood transfusion?

No _____

Yes ____

If yes, when? _____

GASTROINTESTIONAL SYMPTOM REVIEW

Please check if you have had any of the following symptoms or procedures

☐ Ulcer	When?	☐ Upper Endoscopy	When?
☐ Gastritis	When?	☐ Colonoscopy	When?
☐ Hiatal hernia	When?	☐ ERCP	When?
☐ Gallstones	When?	☐ Pill Cam	When?
☐ Pancreatitis	When?	☐ Hemorrhoid Banding	When?
☐ Colon polyps	When?	☐ Feeding Tube Placement	When?
☐ Diverticulitis	When?	☐ Flexible Sigmoidoscopy	When?
☐ Ulcerative Colitis	When?	☐ Biliary Stents	When?
☐ Crohns Disease	When?	☐ Esophageal Stents	When?
☐ Hemorrhoids	When?		
☐ Fissure of Abscess	When?		
☐ Irritable Bowel Syndrome	When?		
☐ Bowel Obstruction	When?		

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion, heartburn
- ☐ frequent belching
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ loose stool
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ vomiting blood
- ☐ stomach pain
- ☐ ulcer
- ☐ black or bloody stool
- ☐ rectal bleeding or blood in stools
- ☐ rectal pain
- ☐ history of liver disease or abnormal liver tests
- ☐ jaundice, hepatitis

Cardiovascular

- ☐ chest pain
- ☐ shortness of breath
- ☐ dizziness
- ☐ passing out
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat, fast heart beat
- ☐ history of poor circulation, swelling of feet ankles, or hands
- ☐ Leg pain

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone

- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in arms or hands
- ☐ pain or weakness or numbness in back or hips
- ☐ pain or weakness or numbness in legs or feet
- ☐ pain or weakness or numbness in neck or shoulders
- ☐ arthritis
- ☐ stiffness in joints
- ☐ pain or cramping in legs

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness
- ☐ tremor or trembles
- ☐ loss of appetite
- ☐ difficulty sleeping
- ☐ difficulty with speech or memory
- ☐ nervousness
- ☐ mood change, anxiety, hallucinations

General

- ☐ weight gain/loss of 10+ lbs. during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ depression

Head and Neck

- ☐ frequent headaches
- ☐ neck lumps or swelling

Eyes, ears, nose, throat

- ☐ eye pain
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing or buzzing in ears
- ☐ frequent nosebleeds
- ☐ ear trouble
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ burning on urination
- ☐ difficulty starting to urinate
- ☐ blood in urine
- ☐ kidney stones
- ☐ syphilis or gonorrhea
- ☐ incontinence
- ☐ sexual dysfunction
- ☐ abnormal Pap smear
- ☐ menstrual difficulties
- ☐ excessive bleeding
- ☐ vaginal discharge
- ☐ bleeding between period
- ☐ mammogram _____
- ☐ prostate problems
- ☐ lumps in testicles
- ☐ foreign discharge

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles
- ☐ change in hair or skin texture

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter Medications	Dose	How often taken

MEDICATIONS:

Prescription medications	Dose	How often taken

Consents and Agreements

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned consents to and authorizes the administration and performance of all treatments, the administration of any needed anesthetics, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications, the performance of diagnostic procedures, the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which in the judgement of the physician or his/her assigned designees may consider medically necessary or advisable. _____ (initials)

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

In consideration of services rendered, I hereby transfer and assign to The Center for Gastrointestinal Health, LLC all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient) for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, and workman's compensation carriers, welfare funds or the patient's employer. _____ (initials)

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned agrees to pay reasonable attorney's fees and collection expense not to exceed 33 1/3% of the outstanding balance. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. _____ (initials)

MEDICARE / MEDICAID

Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____ (initials)

PAYMENT RESPONSIBILITY

I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _____ (initials)

BLOODBORNE PATHOGEN POLICY

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to bodily fluids of a patient in a manner which may according to the current guidelines of the Center of Disease Control, transmit human immunodeficiency virus, the patient whose bodily fluids were involved in the exposure shall be deemed to have consented for testing for infection with HIV. If there is an exposure and the patient's test is positive, the attending physician will notify the patient, any person expose and the Virginia Health department and appropriate counseling will be offered. I have reviewed and understand my patient rights and responsibilities, I certify that I have read and fully understand the above statement and consent full and voluntarily to its contents. _____ (initials)

PATIENT RESPONSIBILITY FOR REFFERAL AND REFERRAL WAIVER

I understand that depending on my insurance coverage it may be necessary to obtain a referral from a Primary Care Physician, I further understand that it is my responsibility to obtain this referral letter from a Primary Care Physician for the specialty services provided to me at The Center for Gastrointestinal Health, LLC. I understand that the referral letter or an authorized referral number is required prior to scheduling this visit in order to assure that it is a covered benefit. I also acknowledge that if I do not have a referral on the date of service, I give my consent and elect to receive care. This required referral letter or authorization must be obtained with five (5) business days of the date of service; it should be dated to the original date of service as noted above.

I understand and agree that if I do not obtain the required letter or authorization within the five (5) business days of the date of service and deliver it to the provider's office, then I will be responsible for payment of any charges and will be billed directly. The insurance carrier will not be responsible for any charges connected with this unauthorized visit. _____ (initials)

PATIENT'S SIGNATURE _____

DATE: _____

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and the Secretary of HHS if I believe my Privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected Health information, and that is practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by The Center for Gastrointestinal Health, LLC, or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. In order to provide quality care for you, there may be times where we have to access your medical records from an area hospital or laboratory facility.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. The Center for Gastrointestinal Health, LLC may or may not agree to restrict the use or disclosure of your protected health information. If The Center for Gastrointestinal Health, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
The Center for Gastrointestinal Health, LLC, reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and given my permission to The Center for Gastrointestinal Health, LLC to use and disclose my health information in accordance with it.

_____
Name of Patient ***(Please Print Clearly)***

_____
Signature of Patient

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Patient's Authorization to Release Medical Information

I understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish The Center for Gastrointestinal Health, LLC to be able to discuss my medical condition. If I change, my mind regarding the release of information to any of the listed people, it is my responsibility to inform The Center for Gastrointestinal Health, LLC in writing of my decision.

In accordance with the above, I _____ *hereby authorize The Center for Gastrointestinal Health, LLC to discuss with and release my medical information to the following individuals:*

Name: _____ *Relationship to patient:* _____
Telephone: _____

Name: _____ *Relationship to patient:* _____
Telephone: _____

Name: _____ *Relationship to patient:* _____
Telephone: _____

Name: _____ *Relationship to patient:* _____
Telephone: _____

Patient Signature: _____ *Date:* _____

(SIGNATURE MUST BE PRESENT FOR NAMES LISTED TO BE VALID)