**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial** \_\_\_\_\_\_

**Patient E-mail**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_\_\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_\_\_\_

**Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthday** \_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_\_**/**\_\_\_\_\_\_\_ **Sex**\_\_\_\_\_ **Marital Status**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation to Patient\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dr.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Dr.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial**\_\_\_\_\_\_\_\_

**Relation to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber Soc. Sec. #\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_\_\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member ID** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient covered by additional insurance? \_\_\_\_\_\_\_\_

**Subscriber Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial**\_\_\_\_\_\_\_\_

**Relation to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthday** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber Soc. Sec. #\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_\_\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member ID** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I, and/or my dependents(s), have insurance coverage and assign directly to Virginia Medical Alliance all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Medicare Patients Only:** I request that payment of authorized Medicare Benefits be made either to me or on my behalf to VMA for any services rendered to me. I authorized any holder of medical information about me needed to determine these payable for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent, Guardian, or Personal Representative, and Relationship to Patient Date

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastroenterology Procedure History**

Last Colonoscopy: \_\_\_\_\_\_\_\_ Last Endoscopy: \_\_\_\_\_\_\_ Last Flexible Sigmoidoscopy: \_\_\_\_\_\_\_\_

**Personal & Family Medical History**

Please check all that apply – indicate family member and/or self

SF- Self, M-Mother, F- Father, B- Brother, S- Sister, U- Uncle, A- Aunt

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Atrial Fibrillation |  | Non-Insulin Diabetes |  | Pancreatitis |  |
| Alzheimer Disease |  | Insulin Diabetes |  | Pulmonary Embolism |  |
| Anxiety |  | Emphysema |  | Peptic Stricture |  |
| Anemia |  | Endometriosis |  | Stroke |  |
| Barrett's Esophagus |  | Fibromyalgia |  | Peptic Ulcer |  |
| Coronary Artery Disease |  | Gallstones |  | Renal Failure |  |
| Cancer |  | H. Pylori |  | Rheumatoid Arthritis |  |
| Colon Polyp |  | HIV |  | Seizure |  |
| Cirrhosis |  | High Cholesterol |  | Sleep Apnea |  |
| COPD |  | High Blood Pressure |  | Ulcerative Colitis |  |
| Crohn's Disease |  | Hyperthyroidism |  | Other Diseases or Medical Problems |  |
| Depression |  | Hypothyroidism |  |  |  |
| Deep Vein Thrombosis clot |  | Hepatitis |  |  |  |
| Diverticulosis |  | Lung Transplant |  |  |  |
| Diverticulitis |  | Osteoporosis |  |  |  |

**Surgical History**

|  |  |  |  |
| --- | --- | --- | --- |
| Year |  | Year |  |
|  |  |  |  |
|  |  |  |  |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of Tobacco (Amount and Length of use): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol (Amount and type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine (Amount and Type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies \_\_\_\_\_ Yes \_\_\_\_\_ No Latex Allergy \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Medications and Dosing Information**

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Please check all the following symptoms that apply to you

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Abdominal Pain |  | Nausea |  | Diarrhea |  | Black tarry stool |  |
| Trouble Swallowing |  | Vomiting |  | Constipation |  | Weight Loss |  |
| Heartburn |  | Change in bowel habits |  | Rectal Bleeding |  | Other |  |

**ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES PATIENTS RIGHTS AND RESPONSIBILITIES**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acknowledge that I have received a copy of Virginia Medical Alliance, Notice of Privacy Practices. This notice describes how VMA may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I also acknowledge that I have been offered a copy of the Patient’s Rights and Responsibilities brochure.

**AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH**

May our office leave messages regarding test results etc. on your answering machine, or with a family member? \_\_\_\_\_\_\_\_ YES or \_\_\_\_\_\_\_ NO

Name and phone number of people we may contact regarding your health and billing.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENTS OF NO SHOW POLICY:** As a courtesy to other patients who wish to see the doctor as quickly as possible, please call to reschedule, or cancel your appointment as soon as possible. If you contact our office more than 24 hours before an office visit and at least 7 days before a procedure you will avoid the no show charge.

If you do not call to cancel your appointment more than **24 hours before an office visit or at least 7 days before a procedure, you will be billed $50 for a missed office visit, $250 for a missed Endoscopy or $500 for a missed Colonoscopy procedure**. Our goal is to provide excellent care to our patients. The no show charge helps us ensure efficient and effective scheduling so that patients may be seen by their doctor as quickly as possible.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_