HAMPTON ROADS GASTROENTEROLOGY, P.C.
Diplomates of the American Board of
Internal Medicine and Gastroenterology
501 Medical Drive
Hampton, VA 23666
www.hamptonroadsgastro.com

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This Patient Form packet contains 3 pages to be completed by the patient. Please fill out all sections completely.

If your insurance policy has changed since your last visit, please contact the office to ensure we participate with your new policy.

When submitting paperwork to the office, please be sure to include the following:

- Front and back copy of your insurance card
- Copy of your photo ID
- Referral from your PCP, if required by your insurance
- Medication list that includes both the name and dosage of the medication
- Ensure page 1 has a valid height and weight listed for the patient
- The section "Statement to Permit Payment of Medicare Benefits to Provider" on the last page only needs to be initialed if you currently have Medicare coverage

Upon receiving all required information, your chart will be submitted to the doctor to review and write the order for the procedure. The office will be contacting you to schedule once the order is written.

Thank you,

The Physicians & Staff at Hampton Roads Gastroenterology

Please circle your provider: CORBETT HASSAN

Requested procedure: UPPER ENDOSCOPY COLONOSCOPY

Hampton Roads Gastroenterology
501 Medical Drive, Hampton VA 23666
Tel: 757-826-3434 Fax: 757-826-9028

Office Use Only: Chart # ____________ NG MRN ___________
Indication for procedure: ______________________________

Name *(Last, First, M.I.)*:		**DOB:**	**Marital Status:** M S D W
Current Age: **Height:** **Weight:** **BMI:** ☐ M ☐ F		**SSN:**	
Home Phone: **Cell Phone:**		**Work Phone:**	**Preferred #:**
Ethnicity (circle): Hispanic/Latino Non-Hispanic/Latino Other Declined to Answer		**Race:**	**Language:**
Home Address: **Apt #:**	**City:**	**State:**	**Zip:** If you have a separate mailing address (PO BOX), please inform the staff.
Employer:	**Occupation:**	**Email:**	
Spouse's Name:	**Spouse's DOB:**	**Spouse's SSN:**	
Primary Insurance: (provide copy of cards)		**Secondary Insurance:**	
Emergency Contact & Phone #:		**Relationship:**	
Primary Care/Referring doctor:		**Cardiologist Name & Phone #:**	
Pulmonologist Name & Phone #:		**Neurologist Name & Phone #:**	
Local Pharmacy:	**Phone #:**	**Mail-Order Pharmacy:**	

Please check any conditions that you have been diagnosed with and/or are currently being treated for:

☐ Asthma	☐ AICD/Defibrillator	☐ Cardiac stent	☐ Peritoneal dialysis	☐ Hemodialysis	☐ Diabetes
☐ COPD	☐ Pacemaker	☐ Mitral valve prolapse	☐ Seizures or epilepsy		☐ Thyroid disease
☐ Emphysema	☐ Arrhythmia/A-fib	☐ Blood clots in lungs (PE)	☐ Hypertension		☐ Colon polyps
☐ Shortness of breath	☐ Heart attack	☐ Blood clots in legs (DVT)	☐ Stroke		☐ Colitis or Crohns disease
☐ Sleep Apnea	☐ Coronary artery disease	☐ Hepatitis or Liver Disease	☐ High cholesterol		☐ Peptic ulcer disease
☐ Use of home oxygen	☐ Heart murmurs or palpitations	☐ Kidney Disease	☐ Migraines		☐ Anemia
☐ Chest pain	☐ Congestive heart failure	☐ Organ Transplant	☐ Arthritis		☐ Cancer: ____________

Other medical conditions:

**Do you take any of the following blood thinners? (please circle) Coumadin Plavix Aggrenox Brilinta Pradaxa Xarelto Effient Eliquis

SURGICAL HISTORY

Check if you have had: ☐ Gallbladder removal ☐ Cardiac bypass ☐ Peptic ulcer surgery ☐ Heart valve ☐ Hysterectomy ☐ Appendectomy

List additional surgeries below:

Date	Surgery	Hospital

List any other hospitalizations in the last 6 months

Date	Reason	Hospital

List your prescribed drugs WITH DOSAGES and over-the-counter drugs, such as vitamins and inhalers (attach list if available)

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

List your drug allergies with reactions **Do you have an allergy to SOY or EGGS (please circle)**

OFFICE USE ONLY Billing Notes: ______________________ Staff Initials: ________ Billing Approval: ________

Scheduled for EGD COLON OFFICE CAREPLEX Date: __________ Time: ________ NG MRN #: __________

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Name *(Last, First)*:	**DOB:**

HEALTH HABITS

Do you drink caffeine?	☐ No	☐ Yes	If yes, circle what type:	Coffee	Tea	Cola		# of cups daily:
Do you drink alcohol?	☐ No	☐ Yes	If yes, circle what type:	Beer	Wine	Liquor	Other	# drinks per week:
Do you use tobacco?	☐ No	☐ Yes	If yes, circle what type:	Cigarettes	Pipe	Cigars	Chew	Vape or Smokeless
	If yes, packs per day?			# of years		Or year quit		

FAMILY HEALTH HISTORY

Please check any family history and indicate which relative.

	Yes (√)	**Relative**		Yes (√)	**Relative**		Yes (√)	**Relative**
Colon polyps	☐		Pancreatic cancer	☐		Celiac disease	☐	
Colon or rectal cancer	☐		Liver cancer	☐		Gallbladder disease	☐	
Stomach cancer	☐		Crohn's disease	☐		Liver disease	☐	
Esophageal cancer	☐		Ulcerative Colitis	☐				

REVIEW OF SYSTEMS

Please check if you are **currently experiencing** any of the following:

Constitutional
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Fever
- ☐ Unintentional weight loss
- ☐ Chills

Eyes
- ☐ Yellow jaundice

Ears/Nose/Throat
- ☐ Hoarseness
- ☐ Sore Throat

Genitourinary
- ☐ Change in urine color

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular heartbeat / Palpitations

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Musculoskeletal
- ☐ Arthritis / Joint pain

Neuro/Psychiatric
- ☐ Headaches
- ☐ Seizures
- ☐ Depression

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance

Skin
- ☐ Rashes
- ☐ Itching

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Easy bruising
- ☐ Easy bleeding

Gastroenterology
- ☐ Abdominal pain
- ☐ Altered bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn / reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Excessive gas
- ☐ Dairy intolerance

PRIOR PROCEDURES AND IMAGING

Have you had any of the following?	Yes (√)	When? (year)	Where?	Result (if known)
Colonoscopy	☐			
Upper endoscopy	☐			
CT Scan Abdomen/Pelvis	☐			
Ultrasound/Sonogram of Abdomen	☐			
Upper GI Series/Barium Swallow	☐			
Lower GI Series/Barium Enema	☐			
☐ None of the above				

OFFICE USE ONLY

HT:	**WT:**	**T:**	**BP:** /	**P:**	**R:**

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Patient Name ________________________________ **Date of Birth** ______________ **MRN #** ________________

Consent for Release of Information for treatment, payment, and health care operations

I hereby authorize Hampton Roads Gastroenterology, P.C. to use and/or disclose my health information which specifically identifies me or which can be reasonably used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Hampton Roads Gastroenterology, P.C. can refuse to treat me.

Initials _________

Assignment of Benefits

I hereby assign all medical insurance benefits to Hampton Roads Gastroenterology, P.C. and understand that even though I have insurance, I am responsible for any and all charges incurred for professional services rendered to me by Hampton Roads Gastroenterology, P.C.. I also understand that should my account become delinquent, I will be responsible for all court costs, collection fees, and attorney fees of 33 1/3% of the unpaid balance, 12% interest will be added to all accounts over 60 days past due. I understand that it is my responsibility to notify the office of any updates or changes in insurance coverage.

Initials _________

Disclosure to Family Members and Friends

Please check appropriately:

I ☐ DO ☐ DO NOT authorize Hampton Roads Gastroenterology, P.C. to speak to my family members/friends regarding my health information.
I ☐ DO ☐ DO NOT authorize Hampton Roads Gastroenterology, P.C. to leave messages on my voicemail regarding my health care information.
I ☐ DO ☐ DO NOT authorize Hampton Roads Gastroenterology, P.C. to contact me via email regarding Patient Portal information.

Initials _________

Notice of Privacy Practices

I acknowledge that Hampton Roads Gastroenterology, P.C. has provided me with a copy of its Notice of Privacy Practices. This notice explains how my health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice. The Medical Practice has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Initials _________

Procedure Cancellation Policy

In the event that you need to cancel or reschedule a procedure, we require 3 BUSINESS DAYS notice. If I do not contact the office in that timeframe or do not show up for my procedure, I will be charged a fee of $150. I will not be rescheduled until the fee is paid. Waiving of the fee is at the doctor's discretion. We will attempt a reminder call twos days prior to your procedure. I understand that if I miss multiple appointments, I will not be rescheduled.

Initials _________ Please also sign below

Statement to Permit Payment of Medicare Benefits to Provider

FOR MEDICARE PATIENTS ONLY

____
HICN (Medicare ID #)

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished me by or in Hampton Roads Gastroenterology, P.C., including physician services. I authorize any holder of the medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services. In addition, I authorize the forwarding of claims to a Medigap insurance plan if applicable.

Initials _________

ALL PATIENTS MUST HAND-SIGN AND DATE BELOW

____________________________________ __________________
Signature of patient or patient's representative Date

____
Printed name of patient or patient's representative