HAMPTON ROADS GASTROENTEROLOGY, P.C.
Diplomates of the American Board of
Internal Medicine and Gastroenterology
303 Butler Farm Road, Suite 103
Hampton, VA 23666
www.hamptonroadsgastro.com

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Telephone (757) 826-3434
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This Patient Form packet contains 3 pages to be completed by the patient. Please fill out all sections completely.

For new "Open Access" patients, these forms allow you to schedule your colonoscopy and/or upper endoscopy (EGD) without an initial office visit with the provider.

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

- Front and back copy of your insurance card
- 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

Forms may be submitted via our website, fax, mail, or dropped off in person.

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

Hampton Roads Gastroenterology

303 Butler Farm Road Suite 103, Hampton VA 23666
Tel: (757) 826-3434 Fax: (757) 826-9028

Please circle your provider: CORBETT HASSAN

Requested procedure: UPPER ENDOSCOPY COLONOSCOPY

OFFICE USE ONLY **NG MRN:** _____

Indication: _____

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	☐ Thyroid disease	☐ Seizures or epilepsy	☐ Syncope/Fainting
☐ 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 Crohn's 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? (circle) Coumadin Plavix Aggrenox Brilinta Pradaxa Xarelto Effient Eliquis

**Do you take any medications for weight loss? (circle) Ozempic Trulicity Byetta Victoza Bydureon Saxenda Wegovy Zepbound Mounjaro Rysbelsus

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)

☐ **CHECK IF NO MEDICATIONS**	3.	6.	9.
1.	4.	7.	10.
2.	5.	8.	11.

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

☐ **CHECK IF NO KNOWN DRUG ALLERGIES**

OFFICE USE ONLY Billing Notes: _____ Staff Initials: _____ Billing Approval: _____

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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
- ☐ Syncope/Fainting episodes/loss of consciousness

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, 3% 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 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 I need to cancel or reschedule a procedure, HRG requires 3 BUSINESS DAYS notice. If I do not contact the office in that timeframe or do not show up for my procedure, I may be charged a fee of $150, or the practice may refuse to reschedule my procedure. The office will attempt a reminder call two days prior to the procedure.

Initials _____

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 to 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 SIGN AND DATE BELOW*****

_____ _____
Signature of patient or patient's representative **Date**

_____
Printed name of patient or patient's representative