Gastrointestinal Medicine Associates, P.C.

Welcome to GMA! We have provided the following information in hopes to make your GMA experience efficient.

Location: We have three office locations. Please verify the location of your appointment with the receptionist when scheduling. Parking instructions are different for each office location.

Co-pay: We collect copays at the time of check-in. A service fee of $13 will be added to copays not collected at time of service.

Medical Insurance: We will submit a claim for your office visit to your insurance. Your insurance may not cover the full cost of the services performed. Any remaining balance is your personal responsibility.

Cancellation/Late Cancellations/No-Show: GMA only sees patient by appointment only. NO WALK-INS. If you can not keep your appointment, please let us know at least 24 hours in advance, so your appointment can be offered to another patient. There is a fee for late cancellations and appointment no-shows, these will be listed in the forms to follow.

Checklist of items to bring to your visit

- ☐ Patient Demographics
- ☐ Authorization and Consent to Treatment/Consent to Call/Preferred Method of Communication
- ☐ Acknowledgement of Office Policies
- ☐ Completed Medical History
- ☐ Front/Back of current medical insurance card
- ☐ Insurance referral if required by your insurance – <u>if you do not have a copy of the correct referral required for your visit, your appointment will be rescheduled</u>
- ☐ Past Medical History
- ☐ <u>If you are being referred for any abnormal labs or imaging findings you must bring a copy of the report with you to the office visit. If we do not have a copy at the time of your appointment, rescheduling may be necessary for your care.</u>

If you have questions regarding your visit, please do not hesitate to contact us. 703-281-1023

We look forward to your visit!

Gastrointestinal Medicine Associates, P.C.

PATIENT INFORMATION

Patient Full Name: ____ DOB: ___________ AGE: ______

Address: ____

City State Zip

Home #: _____________________ Work #: ___________________ Cell #: __________________

SS #: ______________________ □Male □ Female Marital Status: S M D W

Email Address: ____

Preferred Language: ___________________ Race: ________________ Ethnicity: Hispanic or Latino
Non-Hispanic or Latino

Employer: ____________________________________ Occupation: ______________________

Emergency Contact: ____________________________ Phone #: _________________________

Primary Care Physician: _________________________ City, State: _______________________

Referring Physician: ____________________________ City, State: _______________________

Primary Insurance Information:	**Secondary Insurance Information:**
Ins Name: _______________________________	Ins Name: ________________________________
ID #: __________________________________	ID #: ____________________________________
Group #: _______________________________	Group #: _________________________________
Policy Holder Name: _____________________	Policy Holder Name: _______________________
Relation to Pt: __________________________	Relation to Pt: ____________________________
Holders DOB: ____________________________	Holders DOB: ______________________________
Holders SS #: ___________________________	Holders SS #: ______________________________

I / We hereby state that the information provided is true and correct to the best of my / our knowledge.

____________________________ ______________________________ __________________

Signature of Patient / Legal Representative   Printed Name   Date

Gastrointestinal **M**edicine **A**ssociates, P.C.

Authorization and Consent to Treatment

As a GMA patient, I voluntarily consent to the rendering of such care and treatment as the GMA providers and personnel, in their professional judgement, deem necessary for my health and well-being. My consent shall include, but not limited to, medical examination and diagnostic testing. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my GMA provider nor any care center staff has made and guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that GMA may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from GMA.I understand that I may voluntarily "opt-in" to receive automated text message communications from GMA by informing GMA staff or visiting my Athena Patient Portal and agreeing to any additional Terms and Conditions established by my mobile carrier.

Preferred Method of Communication

You have the right to direct how and where GMA communicates with you. Please let us know your preferred method of communication. You may update or change this information at any time; please do so in writing.
I prefer to be contacted in the following manner (check all that apply):

- ☐ Home Tele.: ________________
  - OK to leave message with detailed information
  - Leave message with call-back number only
- ☐ Cell Phone: ___________________
  - OK to leave message with detailed information
  - Leave message with call-back number only
- ☐ Patient Portal
- ☐ Written Communication
  - Please send all my mail to my home address on file
  - Please send all mail to THIS address: _____________________

    ____

    ____

I authorize GMA that family members may have access to my records or to act on my behalf in the coordination of my care. **(Please Circle One)**

YES NO

If yes, only those family members listed below may have access to my records.

Name: __________________________________ Relation: ______________ Phone #: _________________

Name: __________________________________ Relation: ______________ Phone #: _________________

Name: __________________________________ Relation: ______________ Phone #: _________________

____ ________________________

Signature of Patient / Legal Representative Date

____ ________________________

Printed Name Date of Birth

Gastrointestinal Medicine Associates, P.C.

ACKNOWLEDGEMENT AND AUTHORIZATION OF GMA OFFICE POLICIES:

Policies can be found on our website or requested at the time of check in.
Please sign and date each point. Any questions can be answered by our receptionists.

- **I have read and understand the HIPAA/Privacy Policy for Gastrointestinal Medicine Associates, P.C.**

Patient Initials ____________

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Patient Initials ____________

- **I authorize Gastrointestinal Medicine Associates, P.C. to release medical information required to process my claim**

Patient Initials ____________

- **I have read and understand the Financial Policy for Gastrointestinal Medicine Associates, P.C.**

Patient Initials ____________

- **I authorize Gastrointestinal Medicine Associates, P.C.to obtain/have access to my medication history**

Patient Initials ____________

- **I authorize my provider's office to contact me by mobile phone**

Patient Initials ____________

____ ________________________

Patient Signature **Date of Signature**

____ ________________________

Patients Name (Printed) **Patients Date of Birth**

Gastrointestinal Medicine Associates, P.C.

MEDICAL HISTORY FORM

Patient's Name: ___________________________ Today's Date: _____________

Last Visit Date: _____________ Date of Birth: ___________ Age: ______ Sex: M / F

Referring Physician: __________________________ REASON OF TODAYS VISIT: ___________________

Current Height: _____________ Current Weight: ____________

PERSONAL MEDICAL HISTORY **Please check all that apply**

☐ Anemia
☐ Barrett's Esophagus
☐ Cirrhosis
☐ Colitis
☐ Colon Polyps
☐ Crohn's Disease
☐ Diarrhea – Chronic
☐ Diverticulitis
☐ Diverticulosis
☐ Elevated Liver Enzymes
☐ Gallstones
☐ GI Bleed – Upper
☐ GI Bleed – Lower
☐ GERD (Reflux)
☐ Hx of Gout
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Irritable Bowel Syndrome
☐ Liver Disease
☐Hx of MRSA

☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Ulcerative Colitis
☐ Hx of Breast Cancer
☐ Hx of Cervical Cancer
☐ Hx of Colon Cancer
☐ Hx of Esophageal Cancer
☐ Hx of Gastric Cancer
☐ Hx of Prostate Cancer
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Autoimmune Disorder
☐ C H F
☐ COPD/Emphysema
☐ Coronary Artery Disease
☐ CVA / Stroke
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ D V T

☐ Endocarditis
☐ High Cholesterol
☐ Myocardial Infarction
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stone
☐ Neurologic Disorder
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Tuberculosis
☐ Valvular Heart Disease
☐ Obstructive Sleep Apnea

Do you use a CPAP machine? Y / N

☐ Other: ____________
____
☐ NONE OF THE ABOVE

BOWEL HABITS

How many bowel movements do you have per day? _______________

Circle those things that pertain to your bowel movements: Blood/ Mucus/ Black Stools

FAMILY HISTORY Check all that apply. Indicate family member(s) and age of diagnosis

Colon Cancer ________________________ Stomach Cancer ________________________
Colon Polyps _________________________ Liver Disease __________________________
Crohn's Disease _______________________ Pancreatitis ____________________________
Diverticulitis __________________________ Ulcerative Colitis ________________________
Diverticulosis _________________________ Ulcers ________________________________
Gallbladder Disease ___________________ Other ______________________________

SOCIAL HISTORY Check all that apply

Tobacco ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Never smoker ☐ Smoker – current status unknown ☐ Unknown if ever smoked
Alcohol use ☐ No ☐ Yes (Type _____________) (Drinks per day ______) (Drinks per week _____)
Caffeine ☐ No ☐ Yes (Drinks per day _________)
Exercise ☐ No ☐ Yes (Type ________________) (_________ times per week)
Tattoos ☐ No ☐ Yes
Occupation: _________________ Marital Status: _________ Number of Children: _________
Special interest or hobbies: ____

SURGICAL HISTORY AND HOSPITALIZATIONS

☐ None
☐ Please list all surgeries/hospitalizations, dates and reasons

____/____/____ ____

____/____/____ ____

____/____/____ ____

____/____/____ ____

____/____/____ ____

____/____/____ ____

PROCEDURE HISTORY When was your last procedure? What were the results?

☐ Colonoscopy ____/____/____ Normal or ___________________________

☐ Upper Endoscopy (EGD) ____/____/____ Normal or ___________________________

☐ Flexible Sigmoidoscopy ____/____/____ Normal or ___________________________

☐ I have never had any endoscopies

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CURRENT MEDICATIONS

Please list your medications and dosages for each. Include over the counter medications and supplements. (Or attach and updated copy to this packet)

Medication Name	*Dosage*	*Medication Name*	*Dosage*

Do you have any drug allergies? ____

Any other allergies? __________________________

Pharmacy Name: ________________________ Phone Number ___________________

Street Address: ____

The medical information provided is complete and true to my knowledge.

____ ____________________

Signature of Patient / Legal Representative Date