Richmond Gastroenterology Associates

Patient Information Sheet

FORM MUST BE COMPLETED IN FULL TO PROCESS

PATIENT'S FULL NAME:			SEX:
BIRTH DATE:	PATIENT'S STREET ADDRESS:		
ZIP CODE:	CITY:	STATE:	SOCIAL SECURITY NUMBER:
HOME PHONE:	CELL PHONE:	WORK PHONE:	
E-MAIL ADDRESS (FOR PATIENT PORTAL COMMIUNICATION):		MARITAL STATUS:	
EMERGENCY CONTACT NAME AND RELATIONSHIP:		EMERGENCY CONTACT PHONE NUMBER:	
PHARMACY NAME AND PHONE NUMBER:		REFERRING/PRIMARY CARE PHYSICIAN:	
PLEASE SELECT HOW YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS: (CHECK ALL THAT APPLY) ☐ CALL ☐ TEXT ☐ PORTAL ☐ OPT OUT OF ALL REMINDERS		PATIENT'S RACE/ETHNICITY: ☐ DECLINE	

PAYMENT/INSURANCE INFORMATION

PRIMARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):
SECONDARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):
TERTIARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):

☐ **SELF PAY (DEPOSIT REQUIRED)**

Medical Service Contract

I hereby certify that the information I have given is correct and true to the best of my knowledge. I hereby assign Richmond Gastroenterology Associates, Inc. any and all rights and benefits pertaining to their services rendered under any insurance policies, and I authorize said Physicians to release whatever medical information necessary to file said insurance claims and release information necessary for my care and treatment to other professional healthcare providers. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges arising for the treatment of myself (or the above named patient, if applicable). If this contract is referred to a collection agency or attorney for collection, I agree to pay all court costs, including attorneys and collection agency fees in the amount of thirty percent (30%) of all total indebtedness due.

Patient Signature _____ Date _____

Patient's Guardian _____ Date _____

RGA Missed Appointment/ Cancellation Policy

The physicians and staff at Richmond Gastroenterology are here to serve your health care needs in an efficient and timely manner.

To better serve all of our patients, we ask that you let us know as soon as possible if you need to cancel your visit. Missed appointments or cancellations made less than 48 hours prior to the scheduled appointment may cause you to be billed a cancellation/missed appointment fee for the following amounts. These fees are not covered by Health Insurance; you will be billed directly for these charges.

Endoscopy (EGD and/or Colonoscopy)	$100.00
New Patient Office Visit	$50.00
Follow-up Office Visit/ All Other Scheduled Services	$25.00

I understand that I may be charged if I miss my appointment or cancel my appointment per the conditions above. I understand this charge is not covered by my insurance and will be my financial responsibility.

Patient's Name (printed)_____

Signature_____

Date_____

****

Please note: Due to Medicaid regulations this policy does not apply to patients who are covered by any Medicaid funded health care program accepted by our practice (examples: Medicaid, HealthKeepers Plus, Virginia Premier).

I certify that I am covered by a Medicaid funded program:

Name of Program_____

Signature_____

Date_____

PATIENT INTERVIEW FORM

Richmond Gastroenterology Associates

Please mark your answers in applicable box.

Patient name:_____

Patient date of birth: ____ / ____ / ____ Email address: _____

Primary Care Provider:_____

Occupation:_____ Number of Children:_____

Tobacco status: ☐ Never smoked ☐ Current smoker ☐ Former smoker (Date quit: ____ / ____ / ____) ☐ Vaping ☐ Chewing tobacco

Alcohol consumption: ☐ None ☐ Daily ☐ Weekly ☐ Monthly

Exercise: ☐ None ☐ Less than 3/week ☐ 3 or more times/week

Caffeine intake: ☐ None ☐ Daily ☐ Weekly

Drug use: ☐ Never ☐ Current ☐ Former ☐ Recreational ☐ Intravenous

Allergies: ☐ No known allergies ☐ No known drug allergies ☐ Yes (Specify below)

Allergy type:_____ Reaction:_____

Allergy type:_____ Reaction:_____

Allergy type:_____ Reaction:_____

Local pharmacy of choice: _____
(Name) (Address) (Phone number)

Mail order pharmacy: _____
(Name) (Address) (Phone number)

Current medications including over-the-counter drugs, vitamins and herbs: (Provide the dose, frequency and reason for taking).

Medication name	Dose	Frequency	Reason for taking

**If you need additional space for medications, please ask for paper at the check-in desk. If you prefer, we can make a copy of your personal medication list.*

PAST OR PRESENT MEDICAL CONDITIONS

☐ Asthma ☐ COPD/Emphysema ☐ Use Supplemental Oxygen ☐ Tracheotomy ☐ Sleep apnea ☐ Other: _____

☐ High blood pressure ☐ A Fib ☐ Congestive heart failure ☐ Heart attack ☐ Cardiac implant/device: _____ *Date*

☐ Anemia ☐ Arthritis ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High cholesterol ☐ Glaucoma ☐ Organ transplant: _____ *Date*

☐ Kidney disease: _____ *Date* ☐ Liver disease: _____ *Date* ☐ Thyroid disease: _____ *Date*

☐ Hemorrhoids ☐ Crohn's disease ☐ Colitis ☐ Diverticulitis ☐ Hepatitis: _____ *Type*

Previous or Current Infections

☐ COVID-19
When: _____

☐ Tuberculosis
When: _____

☐ Shingles
When: _____

☐ C.Diff
(Clostridioides difficile)
When: _____

☐ MRSA
(Methicillin-resistant Staphylococcus aureus)
When: _____

☐ VRE
(Vancomycin-resistant Enterococci)
When: _____

☐ CRE
(Carbapenem-resistant Enterobacteriaceae)
When: _____

☐ Hepatitis B
When: _____

☐ Autoimmune Hepatitis
When: _____

Cardiac Devices ☐ Pacemaker When: _____ ☐ Defibrillator When: _____ ☐ AICD When: _____

IMMUNIZATIONS

☐ None ☐ Covid-19: _____ *Year* ☐ Flu: _____ *Year* ☐ Pneumovax: _____ *Year* ☐ Hep A: _____ *Year* ☐ Hep B: _____ *Year* ☐ Zoster: _____ *Year*

Other/Comments: _____

_____

SURGICAL AND PROCEDURAL HISTORY

Surgery/Procedure/Test	Date	Provider/Location
☐ None		
☐ Colonoscopy		
☐ EGD		
☐ Other: ☐ ERCP ☐ EUS ☐ Enteroscopy		
☐ Manometry or capsule study		
☐ CT scan or MRI		
☐ Ultrasound		
☐ Liver biopsy		
☐ Gastric emptying study		
☐ UGI/Small bowel follow through		
☐ Barium swallow or Enema		
☐ Surgery *(please specify)*		
☐ Surgery *(please specify)*		
☐ Surgery *(please specify)*		

PERSONAL & FAMILY HISTORY *(Check any that apply)*

Disease/disorder	Self	Grandparent (s)	Parent(s)	Sibling(s)	Child(ren)	Details
Polyps	☐	☐	☐	☐	☐	
Cancer *(specify type)*	☐	☐	☐	☐	☐	
Cancer *(specify type)*	☐	☐	☐	☐	☐	
Crohns/Colitis	☐	☐	☐	☐	☐	
Liver disease	☐	☐	☐	☐	☐	
Problems w/ anesthesia	☐	☐	☐	☐	☐	

REVIEW OF SYSTEMS

Cardiovascular
☐ Chest pain
☐ Irregular heart beat
☐ Palpitations
☐ Swelling in hands/feet
☐ Syncope
☐ Sweats

Constitutional
☐ Fatigue
☐ Fever
☐ Loss of appetite
☐ Weight gain
☐ Weight loss

ENMT
☐ Nose bleeds
☐ Sore throat
☐ Hearing loss

Endocrine
☐ Excessive thirst
☐ Heat intolerance

Eyes
☐ Loss of vision

Gastrointestinal
☐ Abdominal pain
☐ Abdominal swelling
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Bloating/gas
☐ Heartburn
☐ Jaundice
☐ Nausea
☐ Rectal bleeding
☐ Stomach cramps
☐ Vomiting
☐ Difficulty swallowing
☐ Rectal pain
☐ Stool incontinence
☐ Vomiting blood

Genitourinary
☐ Discolored urine
☐ Painful urination
☐ Increased frequency
☐ Bloody urine
☐ Incontinence

Hematologic/Lymphatic
☐ Easy bruising
☐ Prolonged bleeding

Integumentary
☐ Itching
☐ Rash
☐ Sun sensitivity

Musculoskeletal
☐ Arthritis
☐ Back pain
☐ Gout
☐ Joint pain
☐ Muscle weakness
☐ Stiffness

Neurological
☐ Dizziness
☐ Fainting
☐ Frequent headaches
☐ Memory loss

Other
☐ Anxiety
☐ Depression
☐ Difficulty sleeping
☐ Hallucinations
☐ Nervousness
☐ Panic attacks
☐ Paranoia

Respiratory
☐ Cough
☐ Short of breath
☐ Wheezing

Check if you have experienced in the last week.

PATIENT INTERVIEW FORM

Patient name: _____ Patient date of birth: ____ / ____ / ____

- *Please review and sign the authorizations below. You have the right to refuse to sign. Your refusal will not affect your ability to obtain treatment or payment or eligibility of benefits.*
- *These authorizations will remain valid for two years of the signature date unless you revoke prior to that time.*

(initial in box)

I, ☐ consent ☐ do NOT consent to Richmond Gastroenterology Associates, Inc. obtaining medical records from area hospitals to facilitate my care.

(initial in box)

I, ☐ consent ☐ do NOT consent to Richmond Gastroenterology Associates, Inc. sharing medical information with my PCP and/or referring provider to facilitate my care.

I am aware that Richmond Gastroenterology Associates, Inc. is compliant with the Virginia State Code 18 VAC 76-20-70 and may access medication history information.

I am aware that Richmond Gastroenterology Associates, Inc. encourages the use of our Patient Portal. Through the secure Patient Portal, I am able to communicate with my provider and access, download, and transmit my health information online. I was offered instructions to access the Patient Portal.

Patient signature:_____ Date: ____ / ____ / ____

NOTICE OF PRIVACY PRACTICES

Richmond Gastroenterology Associates, Inc. Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice you may obtain a revised copy.

I, _____ was offered a copy of Richmond Gastroenterology Associates, Inc.
Print patient name
Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions of RGA if I do not understand any information in the Notice of Privacy Practices.

Patient signature:_____ Date: ____ / ____ / ____

OPTIONAL AUTHORIZATION

I, _____ hereby authorize Richmond Gastroenterology Associates, Inc. to discuss
Print patient name
my Protected Health Information with:

Name of relative/friend	*Date of birth*	*Relationship to patient*	*Contact number*

Patient signature:_____ Date: ____ / ____ / ____