NOVA INNOVATIVE GASTROENTEROLOGY, PLCC

Patient's name _____ Date _____
Street Address: _____
City _____ State: _____ Zip Code: _____

Cell Phone_____ Work Phone _____ Home Phone _____

Date of Birth: _____ E-mail Address: _____

Sex: (please circle) Male Female Decline to specify
Ethnicity: (please circle) Non-Hispanic Hispanic Other
Race: (please circle) White Asian Hispanic African American Other
Language (please circle) English Spanish Other: _____
Marital Status: (please circle) Married Single Divorced Widowed

Primary Care Physician Name:
_____
Referring Provider Name:
_____

OCCUPATION INFORMATION Employer:
_____
Work phone number:
_____

EMERGENCY CONTACT INFORMATION:
Name: _____ Phone:
_____
Relationship to patient:
_____

Pharmacy Name: _____ Address:
_____

INSURANCE INFORMATION Primary Insurance Name: _____
ID Number: _____Group Number: _____
Name of Insured:_____ Relationship to Insured: _____
Secondary Insurance Name: _____
ID Number: _____Group Number: _____
Name of Insured:_____ Relationship to Insured: _____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS This will authorize the filing of any insurance in force and the direct payment to NOVA Innovative Gastroenterology of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to NOVA Innovative Gastroenterology for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with NOVA Innovative Gastroenterology. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agree that each will be jointly and severally liable and guarantee payment for any or all services rendered. It is further

agreed that the undersigned patient, spouse, and/or responsible party agrees to pay all cost of. Any unpaid balance will be subject to a finance charge of 1.5% per month (18% APR) commencing 60 days from the date of service. I hereby authorize the release of any medical information necessary to process claims.

Patient Signature: _____ Date Signed: _____

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Patient Name: _____ **DOB**: _____ **Date**: _____

Who referred you to us?
□Medical Provider _____ □Friend_____
□ Internet Search □
Other_____

What is the main reason for your visit today?
□Reflux or heartburn □Difficulty swallowing □Abdominal pain □Anemia □Nausea □Vomiting □Gas
□Blood in stool □ Rectal bleeding □Constipation □Diarrhea □Abnormal liver tests □Hepatitis C □Hepatitis B
□Celiac disease □ IBD □ Abnormal CT or x-ray result, where _____
□Screening for colon cancer (colonoscopy)
□ Other: _____

Please list all medical conditions: □High BP (even if treated) □Diabetes □Heart attack or angina
□Asthma/COPD □Sleep apnea □Congestive heart failure □Bleeding disorder
□Other
_____

Please list all medications as well as dosages:
1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you take any pain meds (NSAIDs) or blood thinners (e.g. Coumadin, Plavix, Aspirin, Advil/Motrin/Ibuprofen, Aleve/Naprosyn, BC or Goody Powder, arthritis meds, etc)? □Yes □No
If yes, please list: _____

ALLERGIES/INTOLERANCES: □None □Yes (Please list along with what type of reaction)
Drug/Food_____ Reaction: _____
Drug/Food_____ Reaction: _____
Drug/Food_____ Reaction: _____

Social History
□Yes □No Tobacco Use: □Chew □Smoke, duration _____, amount_____, quit _____
□Yes □No Alcohol use: Type and frequency
_____
□Yes □No Drug use (illegal): Type and frequency
_____

□Married □ Divorced □ Single

Occupation: _____ □ Retired: _____

Any previous GI evaluation? □Yes □No
If so, by whom? _____, City _____, State_____
□Upper GI x-ray
□EGD (upper endoscopy)
□Camera Pill Examination
□Barium enema
□Small bowel x-ray
□Colonoscopy
□Sigmoidoscopy
□CAT Scan or MRI

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Patient Name: _____ **DOB**: _____ **Date**: _____

Family Medical History: Have any of your first-degree relatives (father, mother, brother, sisters, children) been diagnosed with:
□Yes □No Colon polyps or colon cancer Relationship:
_____
□Yes □No Familial polyposis coli Relationship:
_____
□Yes □No Ulcerative colitis or Crohn's disease Relationship:
_____
□Yes □No GI cancer (stomach, liver, or pancreas) Relationship:
_____
□Yes □No Liver disease or hepatitis Relationship:
_____
Previous operations or surgeries: (Please list year and any pertinent information regarding surgery)

SURGERY	YEAR	NOTES	SURGERY	YEAR	NOTES
□Gallbladder:	_____	_____	□Heart bypass/stent	_____	_____
□Stomach (gastric)	_____	_____	□Pacemaker	_____	_____
□Small bowel/Colon	_____	_____	□Heart Valve	_____	_____
□Hysterectomy/Ovary	_____	_____	□Vascular	_____	_____
□Appendix	_____	_____	□Other	_____	_____

Please fill out the information below regarding your clinical condition by checking yes or no.
Heartburn ___Yes ___No
Difficulty swallowing ___Yes ___ No
Nausea ___Yes ___No
Diarrhea ___Yes ___No
Vomiting ___Yes ___No
Abdominal pain ___Yes ___No
Constipation ___Yes ___No ___
Rectal bleeding ___Yes ___No

Black stools ___Yes ___No
Chest pain ___Yes ___No
Shortness of breath ___ Yes ___No
Eye pain/irritation ___ Yes ___ No
Nasal congestion ___ Yes ___ No
Nosebleeds ___ Yes ___ No
Ear pain/hearing loss ___ Yes ___ No
Easy bruising/bleeding ___ Yes ___ No
Cough or wheezing ___Yes ___No
Weight loss/gain ___ Yes ___ No
Back or neck pain ___ Yes ___ No
Muscle cramping ___ Yes ___ No
Dizziness/vertigo ___ Yes ___ No
Seizures ___ Yes ___ No
Anxiety ___ Yes ___ No
Suicidal ideas ___ Yes ___ No
Loss of sleep ___ Yes ___ No
Cough ___ Yes ___ No
Cough ___ Yes ___ No
Abnormal liver enzymes ___ Yes ___ No

Fecal incontinence ___Yes ___No
Leg swelling ___Yes ___No
Artificial heart valve ___ Yes ___No
Blurred vision ___ Yes ___ No
Post Nasal Drip Yes ___ No
Sore throat ___ Yes ___ No
Night sweats ___ Yes ___ No
Skin irritation/rash ___ Yes ___ No
Fatigue ___ Yes ___ No
Fever ___ Yes ___ No
Joint pain ___ Yes ___ No
Headaches ___ Yes ___ No
Fainting ___ Yes ___ No
Weakness ___ Yes ___ No
Depression ___ Yes ___ No
Substance abuse ___ Yes ___ No
Situational stress ___ Yes ___ No
Shortness of breath ___ Yes ___ No
Anemia ___ Yes ___ No
Jaundice ___ Yes ___ No

_____
Patient signature

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Patient's name _____ Date _____

CONSENT FORM:
_____(initial) I understand that the laws of Virginia provide if my physician or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which may according to the then current guidelines for the Center of Disease Control transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

Acknowledgement of HIPAA Privacy Practices/Cancellation/No Show Policy
_____ (initial) I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices, as well as the cancellation/no show policy of NOVA Innovative Gastroenterology, PLLC, available upon request.

Release of Information: I, hereby authorize NOVA Innovative Gastroenterology, PLCC, to release pertinent medical information verbally to the following:

Name: _____Relationship: _____
Name: _____Relationship: _____
Name: _____Relationship: _____

Name: _____Relationship: _____

I may revoke this release at any time.

Okay to leave a message on my home or cell phone: ___ Yes ____ No

I give permission to access my prescription history from external source: ____Yes ____No

I give permission for SMS communications (text messaging) : _____Yes ____ No

_____
Patient signature

OR Personal Representative Information:
I hereby acknowledge that I am the personal representative of the above-mentioned patient.

Printed Name of the Personal Representative: _____

Signature: _____ Signature Date: _____