



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:	<input type="checkbox"/> M	<input type="checkbox"/> 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:

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

<input type="checkbox"/> CHECK IF NO MEDICATIONS		
3.	6.	9.
1.	4.	7.
2.	5.	8.
		10.
		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: _____

Name <i>(Last, First):</i>	DOB:
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HEALTH HABITS

Do you drink caffeine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, circle what type:	Coffee	Tea	Cola	# of cups daily:	
Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, circle what type:	Beer	Wine	Liquor	Other	# drinks per week:
Do you use tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> 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
Colon polyps	<input type="checkbox"/>		Pancreatic cancer	<input type="checkbox"/>	
Colon or rectal cancer	<input type="checkbox"/>		Liver cancer	<input type="checkbox"/>	
Stomach cancer	<input type="checkbox"/>		Crohn's disease	<input type="checkbox"/>	
Esophageal cancer	<input type="checkbox"/>		Ulcerative Colitis	<input type="checkbox"/>	

REVIEW OF SYSTEMS

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

Constitutional	Cardiovascular	Endocrine	Gastroenterology
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Irregular heartbeat / Palpitations	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Altered bowel habits
<input type="checkbox"/> Fever			<input type="checkbox"/> Constipation
<input type="checkbox"/> Unintentional weight loss	Respiratory	Skin	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Chills	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Rashes	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Cough	<input type="checkbox"/> Itching	<input type="checkbox"/> Heartburn / reflux
Eyes	<input type="checkbox"/> Wheezing	Hematologic/Lymphatic	<input type="checkbox"/> Nausea
<input type="checkbox"/> Yellow jaundice	Musculoskeletal	<input type="checkbox"/> Anemia	<input type="checkbox"/> Vomiting
Ears/Nose/Throat	<input type="checkbox"/> Arthritis / Joint pain	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Hoarseness	Neuro/Psychiatric	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Excessive gas
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Headaches		<input type="checkbox"/> Dairy intolerance
Genitourinary	<input type="checkbox"/> Seizures		
<input type="checkbox"/> Change in urine color	<input type="checkbox"/> Depression		

PRIOR PROCEDURES AND IMAGING

Have you had any of the following?	Yes (√)	When? (year)	Where?	Result (if known)
Colonoscopy	<input type="checkbox"/>			
Upper endoscopy	<input type="checkbox"/>			
CT Scan Abdomen/Pelvis	<input type="checkbox"/>			
Ultrasound/Sonogram of Abdomen	<input type="checkbox"/>			
Upper GI Series/Barium Swallow	<input type="checkbox"/>			
Lower GI Series/Barium Enema	<input type="checkbox"/>			
<input type="checkbox"/> 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 two 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