GASTROENTEROLOGY & HEPATOLOGY CENTER
Sanjeev M. Wasan, M.D., PLC
19420 Golf Vista Plaza, Suite 230A, Lansdowne, VA 20176
Phone: (703) 724-4480 Fax: (703) 724-7743
www.gihepcenter.com

PATIENT REGISTRATION FORM

PATIENT'S NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ MOBILE #: _____WORK#: _____

EMAIL: _____

Gender: Male / Female AGE: _____ DATE OF BIRTH: _____

SSN#: _____ MARITAL STATUS: _____

OCCUPATION:_____

NAME OF EMPLOYER: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT #: _____

POLICY-HOLDER OF INSURANCE: _____

RELATION TO PATIENT: _____

POLICY HOLDER'S DOB: _____ POLICY HOLDER SSN#: _____

NAME OF INSURANCE COMPANY: _____

INSURANCE ID#: _____ GROUP#: _____

WHO REFERRED YOU TO THIS PRACTICE: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER WHERE WE MAY LEAVE MESSAGES FOR YOU REGARDING APPOINTMENTS, LAB RESULTS, OR FOLLOW-UP CALLS:

_____

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MEDICAL HISTORY FORM

Please indicate reason for visit/chief complaint: _____

Please List all *MEDICAL CONDITIONS* or problems (past or present):

1. **5.**

2. **6.**

3. **7.**

4. **8.**

Please List all prior *SURGERIES* and include dates:

1. **4.**

2. **5.**

3. **6.**

List all Prescribed *MEDICATIONS* (include dosages): ***SUPPLEMENTS / OTC MEDICATIONS*:**

1. **1.**

2. **2.**

3. **3.**

4. **4.**

5. **5.**

6. **6.**

Please indicate if you take any of the following on a daily basis:

Aspirin / Xarelto / Coumadin / Motrin / Advil / Aleve / Plavix / Effient / Pradaxa / Eliquis

Please List all Medications that you are *ALLERGIC* to including type of reaction:

_____

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List any medical conditions, including cancer, in your *FAMILY* (indicate who had what condition):

Please indicate which of the following tests you have had done, date, and doctor performing that test.

Colonoscopy --

Upper Endoscopy (EGD) --

Sigmoidoscopy --

ERCP --

HIDA scan --

CT scan --

Upper GI series --

Ultrasound (type) --

Social History

Tobacco Use: YES NO

If a smoker, how much do you smoke per day: _____

If previous smoker, when did you quit: _____

Vape Use: YES NO

Cannabinoid Use: YES NO

Indicate number of alcoholic drinks per week (Including beer/wine): _____

If previous drinker, when did you quit: _____

Indicate number of cups of caffeine-containing drinks/day: _____

Number of Children: _____

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REVIEW OF SYSTEMS: (circle all that apply or "None / N/A")

1. Constitutional: Weight loss / Weight gain / Fatigue / Fever

2. Eyes: Blurry vision / Red eyes / Watery eyes / Eye pain / Dry Eyes

3. Ears/Nose/Mouth/Throat: Hearing loss / Nose bleeds / Nasal allergies / Cold sores / Frequent sore throats / Hoarseness / Dry mouth

4. Lungs: Difficulty breathing / Cough / Wheezing / Shortness of breath / Shortness of breath with exertion / Asthma

5. Heart: Chest pain / High cholesterol / High blood pressure / Heart murmur / Palpitations / Heart valve problems / Mitral valve prolapse

6. Gastrointestinal: Abdominal pain / Difficulty swallowing / Diarrhea / Constipation / Gas bloating / Belching / Excessive Flatulence / Nausea / Vomiting / Heartburn/Reflux / Fecal incontinence / Hemorrhoids / Bleeding

7. Endocrine: Diabetes / Thyroid problems / Excessive thirst / hot/cold flashes / night sweats

8. Neurologic: Headaches / Seizures / Dizziness / Difficulty walking / peripheral neuropathy / loss of feeling in hands or feet

9. Rheumatologic: Joint pain (where: _____) / Scoliosis / Herniated discs / Sciatica

10. Skin: Rashes (where: _____) / Itching / New moles

11. Urinary: Urinary problems / Blood in urine / urine incontinence / Difficulty starting or stopping / Herpes / Impotence

12. Gynecologic: Heavy menses / Irregular menses / pain with intercourse

13. Obstetrical: Number of pregnancies: _____ Miscarriages/Abortions: _____

14. Psychiatric: Anxiety / Depression / Bipolar / Schizophrenia

15. Hematology/Oncology: Cancer / Anemia / Low platelets / Low white count / Sickle cell anemia / Easy bruising

16. History of MRSA: YES / NO

17. Problems with Anesthesia/sedation in the past: YES / NO

18. Food Intolerances: _____

19. History of COVID-19? YES / NO If YES, When did you last have COVID-19? _____

20. Had COVID-19 Vaccination? YES / NO

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VIRAL HEPATITIS SCREENING

Have you had or participated in any of the following (check box if yes):

❏ Born between 1945 and 1965 and not previously tested for Hepatitis C

❏ Blood transfusion, if so when _____
❏ IV drug use and/or sharing of contaminated needles/syringes.

❏ Street/recreational drug use.

❏ Intranasal drug use.

❏ Tattoos

❏ Body piercings of any kind (Except ears)

❏ Unprotected and/or risky sexual activity, including multiple or high-risk partners.

❏ Any kind of contact with possibly contaminated blood and/or other bodily fluids.

❏ Needle sticks from possible high-risk sources.
❏ History of Hepatitis B, if so when _____

❏ History of Hepatitis C, if so when _____

❏ History of HIV

❏ Close contact with an individual who has/had Hepatitis B, Hepatitis C, or HIV.

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RELEASE OF INFORMATION/CONFIDENTIALITY AGREEMENT

(Please CHECK the boxes that you agree to and initial in the margin next to that box)

_____ ← List ALL individuals that you GRANT ACCESS to your medical information, including discussing your medical care and results of tests.

List Names:

_____ _____

_____ _____

_____ _____

_____ _____

_____ 🔄 I hereby grant permission for Dr. Sanjeev M. Wasan and staff to leave V.M. messages for me regarding appointments or results of any tests I have had on an answering service at the following number: _____.

_____ 🔄 I hereby grant permission for Dr. Sanjeev M. Wasan and staff to send MMS text messages and/or Emails regarding appointments, procedure reminders and outstanding balances.

This authorization can be revoked at any time in writing.

_____
Patient's Signature Date

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PATIENT FINANCIAL POLICY

This practice has contracts with most insurance companies. We are not in-network with Medicaid plans or the Affordable Care Act Plans available on the Marketplace Healthcare Exchange. Please check with our staff to determine whether we accept your insurance plan.

If we have contact with your plan, we will file a claim with your insurance company upon receipt of a current insurance card. You are responsible for all charges that are not covered by your insurance company (i.e. deductibles, copays for specialist visit, co-insurance). These amounts will be due at time of visit or within one month of your visit. A bill will be mailed to your home and/or emailed to you once we get the EOB (explanation of benefits) from your insurance company and will need to be paid by or before the due date.

We accept personal checks, VISA, Mastercard, Discover, American Express and cash as forms of payment. There is a $30 charge for all returned checks.

Your co-pay for a specialist office visit is **due at the time** of your office visit. If you are part of an HMO or your insurance plan requires a referral to be seen, you are responsible to obtain a referral from your primary care physician **BEFORE** your visit with us. If a referral is not obtained at the time of your visit, you will be responsible for the entire amount of the visit at the time of service.

Please be advised that if therapy is performed (i.e. removal of polyps, biopsy, dilation, etc.) during your endoscopic procedure, you may be subject to an **additional charge** depending on your policy with your insurance company.

If you fail to pay your balance to the Gastroenterology and Hepatology Center and it becomes necessary to take action to collect on your account, you agree to pay for all costs in the collection of your balance including any collection agency and/or attorney fees.

All procedures are performed at either the INOVA Loudoun Ambulatory Surgery Center or at the INOVA Loudoun Hospital Center as an outpatient procedure. Please note that you will be financially responsible for any **facility, pathology, anesthesia, or other fees** associated with the procedure outside of Dr. Wasan's fees. To find out what your financial responsibilities for these services may be please contact your insurance company and/or billing office of the previously mentioned service providers.

The Gastroenterology and Hepatology Center has a **24** hour (business day hours) cancellation policy for office appointments and a **72** hour (business day hours) cancellation policy for procedures. There is a **$100** fee for missed new patient office appointments and a **$75** fee for missed established patient office appointments or cancellations made within **24** hours (business day hours) of the scheduled appointment. There is a **$250** fee for all missed scheduled endoscopy procedures, a **$200** fee for cancellations made within **72** hours (business day hours) of the procedure, a **$500** fee for procedures that have been scheduled for a **second time** and missed or canceled within **72** hours (business day hours) of the procedure. For any **third** missed or canceled procedure within **72** hours (business day hours) of the procedure you will be charged a **$500** fee and **dismissed** from our practice.

Inability to follow your preparation instructions for any procedure you are scheduled for may result in the cancellation of the procedure and subject to the cancellation fee of **$200**.

I have ready and understand the financial policy of the Gastroenterology and Hepatology Center and agree to comply with it.

Signature of Patient/Responsible Party:_____

Printed Name of Patient: _____ Date: _____

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I, the undersigned, have insurance coverage with _____(insurance company name) and assign benefits, if any, directly to the Gastroenterology and Hepatology Center, otherwise payable to the insured for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If any amount due remains unpaid after a bill is rendered, I agree to pay all costs of collection, including reasonable attorney fees. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions.

_____ _____
Signature of Insured Date

Release of Medical Records to Our Practice from Other Health Care Providers
I, the undersigned, authorize the Gastroenterology and Hepatology Center, to obtain any medical records that pertain to my medical care. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and thereby release the Gastroenterology and Hepatology Center and it's physician and staff from all legal responsibility that may arise from the authorized.

_____ _____
Patient's Signature Date

Notice of Privacy Practices
I am aware that there is a copy of the Gastroenterology and Hepatology Center's Notice of Privacy Practices available for my review. If you wish to have a copy, please do not hesitate to ask for one.

_____ _____
Patient's Signature Date

Medicare Authorization
I request that payment of authorized Medicare benefits be made on my behalf to the Gastroenterology and Hepatology Center for any services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay my claims. If "other health insurance" is indicated in item 9a of the CMS-1500 form or elsewhere on the approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

_____ _____
Patient's Signature Date

Consent for Purposes of Treatment, Payment and Health Care Operation
I consent to the use or disclosure of my protected health information by the Gastroenterology and Hepatology Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Gastroenterology and Hepatology Center. I have the right to revoke this consent, in writing, at any time, except to the extent that Sanjeev M. Wasan, M.D. or the Gastroenterology and Hepatology Center's taken action, relying on this consent. "Protected health information" is the health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information involves my past, present, or future physical or mental health condition and identifies me (or on a reasonable basis, identifies me).

_____ _____
Patient's Signature Date