MITCHELL ENDOSCOPY CENTER

7605 Forest Avenue, Suite 211
Richmond, VA 23229
(804) 282-3114

PATIENT REGISTRATION FORM

PATIENT INFORMATION

TITLE	FIRST NAME	M.I.	LAST NAME		
ADDRESS		CITY		STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE		SSN#	
BIRTHDATE	CIRCLE ONE MALE / FEMALE	MARITAL STATUS	SPOUSE'S NAME		
EMPLOYER		OCCUPATION			
WORK ADDRESS		CITY		STATE	ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		TELEPHONE NUMBER	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP
ID#	GROUP #	SUBSCRIBER'S NAME	DATE OF BIRTH
SECONDARY INSURANCE COMPANY		TELEPHONE NUMBER	
CLAIMS MAILING ADDRESS		CITY	STATE	ZIP
ID#	GROUP #	SUBSCRIBER'S NAME	DATE OF BIRTH

I authorize Mitchell Endoscopy Center to release information required by my insurance company. I authorize payment of benefits directly to Mitchell Endoscopy Center. I understand that I am financially responsible to Mitchell Endoscopy Center for charges not covered by this assignment and in the event of default, I agree to pay all costs of collections including reasonable attorney fees. This authorization and assigment will remain in effect until a notification of change is received by Mitchell Endoscopy Center.

Signature: _____ **Date:** _____

MEDICARE LONG-TERM AGREEMENT

I authorize Mitchell Endoscopy Center to release any information needed for Medicare claims to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers.

Signature: _____ **Date:** _____

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FOR OFFICE USE ONLY

ARRIVAL TIME:_____

DATE OF PROCEDURE: _____

PRE-PROCEDURE ASSESSMENT

Name: _____ DOB _____ Family Doctor: _____

Why are you having this procedure? _____

_____

Who is driving you home? _____ Is he/she here now? Yes ☐ No ☐

Medical & Surgical History:	Yes	No	**If yes, please explain:**
Do you have an Advanced Directive?			
Heart Murmur/Valvular Heart Problem?			
Coronary Artery Disease, Arrhythmias, A-Fib?			
Pacemaker or Defibrillator?			
Stroke or TIA (mini Stroke)?			
Seizure?			
Liver Disease?			
Kidney Problems?			
Respiratory Lung Problems (Asthma, COPD)?			
Sleep Apnea? Do you use a CPAP or BIPAP?			
Bowel Disease or Surgery?			
Cancer?			
Glaucoma?			
High Blood Pressure?			
Blood Disorder (HIV,Anemia, Hepatitis)?			
Previous Problems with Sedation/Anesthesia?			
Are you wearing dentures?			
Are you wearing a hearing aid?			
Do you have artificial joints/implants?			
Are you pregnant? N/A ☐			**Last menstrual period:**

Are you on blood thinners? **Circle:** Coumadin, Aspirin, Plavix, Eliquis, Xarelto, Brilinta, Aggrenox

Other medical issues not listed above? _____

Please list any previous surgeries? _____

Drug Allergies: Yes ☐ No ☐ If yes, list: _____

Latex Allergy/Sensitivity: Yes ☐ No ☐ What bowel prep did you use: _____

Tobacco Use: Y N # Pack: _____ Last time you ate solid food: _____@_____

Alcohol Use: Y N Amount: _____ Last time you had liquids: _____@_____

Recreational Drug Use: _____ Height: _____ Weight: _____

Medication	Dosage/Frequency	Reason for Taking	Last Taken on

Completed by (Patient's Signature): _____ Date: _____

Reviewed by (Nurse's Signature): _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

A copy of Mitchell Endoscopy Center **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state laws, has been made available to me. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations permitting to medical assigment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g. spouse, mother, father, etc.)

Relationship: _____ **Witnessed by:** _____

_____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _____

By (name and title): _____

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DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

I, _____, understand that disclosures may be made to my family and friends related to my health or as needed for payment for health care services. I understand that my doctor will only disclose information relevant to current treatment. I agree that my doctor may disclose health care information to:

(complete all that apply)

Name	Relationship	In Person	By Phone

I authorize Mitchell Endoscopy Center to leave messages, test results and/or appointment information on my answering machine or voice mail.

Phone Number(s) _____

Patient Signature _____ Date _____

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MEDICATION LIST

Date _____

Name _____ DOB _____

Local Pharmacy _____ PH# _____

Mail Order Pharmacy _____ PH# _____

DRUG NAME	DOSAGE	FREQUENCY

Vaccinations: ☐ FLU – DATE _____ ☐ PNEUMONIA – DATE _____

_____ _____

Physician's Signature Date