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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MEDICAL HISTORY

Date: ______________________

First Name: ______________________ Middle Initial: _____ Last Name: ______________________

Date of Birth: ______________________ Referring Physician: ______________________

Why are you here? ______________________

____

____

Past Medical History/Surgeries: ______________________

____

____

____

____

Family History:	Circle One		Relationship	Age Diagnosed
Colon Cancer	YES	NO	______________	________
Colon Polyps	YES	NO	______________	________
Esophageal Cancer	YES	NO	______________	________
Stomach Ulcers	YES	NO	______________	________
Colitis	YES	NO	______________	________
Diabetes	YES	NO	______________	________
High Blood Pressure	YES	NO	______________	________

Do You Smoke	NO	YES - HOW MUCH ______________	Counseling Done ________
Do You Drink Alcohol	NO	YES - HOW MUCH ______________	Counseling Done ________

______________________ Physician's Signature

______________________ Date Reviewed

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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