MITCHELL ENDOSCOPY CENTER

7605 Forest Avenue, Ste 211
Richmond, VA 23229
(804)282-3114
Tax ID 54-2008646

PATIENT REGISTRATION FORM

PATIENT INFORMATION

TITLE NAME	FIRST	M.I.	LAST	
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	SSN#	
BIRTHDATE	CIRCLE ONE MALE / FEMALE	RACE	MARITAL STATUS	SPOUSE'S NAME
PATIENT'S EMPLOYER		PATIENT'S OCCUPATION		
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 Independent Associates, P.C. to release information required by my insurance company. I authorize payment of benefits directly to Independent Associates, P.C.. I understand that I am financially responsible to Independent Associates, P.C. for charges not covered by this assignment and in the event of default, I agree to pay all costs of collections including reasonable attorney fee's. This authorization and assigment will remain in effect until a notification of change is received by Independent Associates, P.C..

Signature: ______________________________________ **Date:** _____________________

MEDICARE LONG-TERM AGREEMENT

I authorize Independent Associates, P.C. to release any information needed for Medicare claims to the Social Security Administration and Health Care Financing Administration or its intermedieaaries or carriers.

Signature: ______________________________________ **Date:**_____________________

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Acknowledgement of Receipt of Privacy Notice

A copy of Independent Associates, P.C. **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:** ___________________

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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 the 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. Below I have provided **MY PERSONAL PHONE NUMBER** where messages can be left.

PHONE NUMBER(S) ____

PATIENT SIGNATURE: ______________________________________ **DATE**: _________________

FOR OFFICE USE ONLY
DATE OF PROCEDURE:____________
ARRIVAL TIME:__________________

MITCHELL ENDOSCOPY CENTER

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

Past Medical & Surgical History:	YES	NO	If yes, please explain:
Do you have an Advanced Directive?			
Heart Murmur/Valvular Heart Problem?			
Heart Disease (Coronary Artery Disease, Arrhythmias, A-Fib)?			
Pacemaker or Defibrillator?			
Stroke or TIA (mini stroke)?			
Seizure?			
Liver Diseases?			
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)?			
Diabetes?			
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			Date of last menstrual period:
Are you on blood thinners? **Circle:** Coumadin, Aspirin, Plavix, Eliquis, Xarelto, Brilinta, Aggrenox			Other: ________________________________ Date stopped: __________________________

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 # Packs:___________ 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_________________