GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, P.C.
ADVANCED DIGESTIVE CARE, LLC
4660 KENMORE AVENUE, SUITE 810, ALEXANDRIA, VIRGINIA 22304
Phone: (703) 823-0333 Fax: (703) 823-8611

SURESH K. MALHOTRA, M.D., F.A.C.P., A.G.A.F.
RONALD J BARKIN, M.D.
SONIA MABOUT, PA-C
JENNIFER WEISS, PA-C

PATIENT INFORMATION- Please PRINT CLEARLY in BLUE or BLACK INK

FIRST NAME _____ MIDDLE _____ LAST _____

SEX M / F DATE OF BIRTH _____/_____/_____ MARITAL STATUS ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED

RACE ☐ ASIAN ☐ AFRICIAN AMERICAN ☐ CAUCASIAN ☐ PACIFIC ISLANDER ☐ OTHER _____

HOME ADDRESS _____ UNIT/APT #_____

CITY _____ STATE _____ ZIP PLUS FOUR CODE _____

HOME PHONE _____ WORK PHONE _____

MOBILE PHONE _____ PREFERRED CONTACT # ☐ HOME ☐ WORK ☐ MOBILE

EMPLOYER_____ ☐ EMPLOYED ☐ RETIRED ☐ STUDENT ☐ OTHER _____

FINANCIALLY REPSPONSIBLE PERSON ☐ PATIENT/SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____

☐ SELF-REFERRED **OR** REFERRING PHYSICIAN _____ PHONE# _____

REFERRING PHYSICIAN ADDRESS _____

INSURANCE INFORMATION- Please provide your insurance card(s) and picture ID to the receptionist.

PRIMARY INSURANCE COMPANY_____

INSURED/CARD HOLDER'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH of PRIMARY CARD HOLDER if not self_____/_____/_____

POLICY #_____ GROUP #_____

SECONDARY INSURANCE COMPANY_____

INSURED/CARD HOLDER'S NAME _____ RELATIONSHIP _____

POLICY #_____ GROUP #_____

PRESCRIPTION BENEFITS COMPANY _____ OR CHECK ☐ SAME AS PRIMARY INSURANCE

PRESCRIPTION/RX MEMBER SERVICES PHONE # _____ RX BIN/ID #_____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PH #_____

Patient's Authorization- NOTE: IN ALL CASES, BILLS ARE THE PATIENT'S RESPONSIBILITY

I, _____ hereby authorize Gastroenterology & Hepatology Associates, P.C. / Advanced Digestive Care, to apply for benefits on my behalf for covered services rendered and request that payments _____ from my insurance be made directly to Gastroenterology & Hepatology Associates, P.C. / Advanced (insurance company name) Digestive Care. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claim, to the above named billing agent. I understand that any unpaid balance will be my responsibility. I understand that any unpaid balance after ninety days may be sent to collections. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

_____ _____

Signature of subscriber or beneficiary **Date**

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HISTORY & PHYSICAL

NAME _____ SEX M / F DATE OF BIRTH____/____/____

REASON FOR VISIT _____ TODAY'S DATE ____/____/____

PHARMACY PHONE # _____ REFERRING/PRIMARY DOCTOR _____

PERSONAL MEDICAL HISTORY
(Check all that apply)

- ☐ History of cancer
- ☐ Neurological Disorders (seizures, migraines, MS/MD)
- ☐ History of Anemia/blood disorder
- ☐ Thyroid disorder
- ☐ Asthma/Emphysema
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ History of Stroke
- ☐ Heart Problems (Coronary Disease, Irregular heartbeat, Heart Attack)
- ☐ OTHER

FAMILY MEDICAL HISTORY
Does anyone in your family have:
If yes, please specify whom (i.e. mother, brother, uncle)

- ☐ Cancer (Type/Who)
  - ☐ Colon _____ ☐ Liver _____
  - ☐ Other (Type/Who) _____
- ☐ Colon polyps
- ☐ Liver disease
- ☐ Stomach ulcers
- ☐ Heart disease / stroke / high blood pressure
- ☐ Diabetes
- ☐ Other

PAST SURGERIES (Include dates if available)

List any ALLERGIES to any medications and/or materials you have including REACTIONS:
☐ Check if you have NO allergies

Do you smoke?
If yes, how many cigarettes per day?
Approximately how long?
Quit date

Do you drink caffeine? Coffee Soda Tea

How many cups daily?

Do you drink alcohol?

How many drinks per week?

List any MEDICATIONS (include vitamins/over the counter medications) you are currently taking with the *DOSE and HOW OFTEN*.
Example: Lipitor 10 mg once/day

PHYSICIAN NOTES / PRACTITIONER SIGNATURE

GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, P.C. SURESH K. MALHOTRA, M.D., F.A.C.P., A.G.A.F.
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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Gastroenterology & Hepatology Associates, P.C./Advanced Digestive Care, LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be 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, Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC can refuse to treat me.

I have been informed that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC in writing, but if I revoke my consent, such revocation will not affect any actions that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC took before receiving my revocation.

I understand that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC has reserved the right to change the privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Gastroenterology & Hepatology Associates, P./ Advanced Digestive Care, LLC must adhere to such restrictions.

I have been informed that if I cancel any office visits with less than 24 hours notice, there is a $50 fee. If I cancel any facility procedures with less than 42 hours notice, there is a $200 fee. Disability forms that need to be completed by a practitioner, incur a $50 fee. FMLA forms that need to be completed by a practitioner incur a $25 fee.

I authorize Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC to share confidential information with the following individual(s).

☐ Spouse Name/Number _____

☐ Parent(s) Name/Number _____

☐ Other- list name/relationship/Number _____

I authorize Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC to leave confidential medical information on the following answering machine number(s).

☐ Home Number _____ ☐ Work Number _____

☐ Cell Number _____

I understand that it is my responsibility to update this information in writing as needed.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ _____

Printed name of patient/patient's representative **Relationship to the patient**