



# Richmond Gastroenterology Associates

Patient Information Sheet  
\*FORM MUST BE COMPLETED IN FULL TO PROCESS\*

PATIENT'S FULL NAME:			SEX:	
BIRTH DATE:		PATIENT'S STREET ADDRESS:		
ZIP CODE:		CITY:	STATE:	SOCIAL SECURITY NUMBER:
HOME PHONE:		CELL PHONE:	WORK PHONE:	
E-MAIL ADDRESS (FOR PATIENT PORTAL COMMUNICATION):			MARITAL STATUS:	
EMERGENCY CONTACT NAME AND RELATIONSHIP:			EMERGENCY CONTACT PHONE NUMBER:	
PHARMACY NAME AND PHONE NUMBER:			REFERRING/PRIMARY CARE PHYSICIAN:	
PLEASE SELECT HOW YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS: (CHECK ALL THAT APPLY) <input type="checkbox"/> CALL <input type="checkbox"/> TEXT <input type="checkbox"/> PORTAL <input type="checkbox"/> OPT OUT OF ALL REMINDERS			PATIENT'S RACE/ETHNICITY: <input type="checkbox"/> DECLINE	

## PAYMENT/INSURANCE INFORMATION

PRIMARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):
SECONDARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):
TERTIARY INSURANCE NAME AND POLICY ID:	SUBSCRIBER NAME AND DATE OF BIRTH (IF OTHER THAN SELF):

☐ **SELF PAY (DEPOSIT REQUIRED)**

## Medical Service Contract

I hereby certify that the information I have given is correct and true to the best of my knowledge. I hereby assign Richmond Gastroenterology Associates, Inc. any and all rights and benefits pertaining to their services rendered under any insurance policies, and I authorize said Physicians to release whatever medical information necessary to file said insurance claims and release information necessary for my care and treatment to other professional healthcare providers. I understand that regardless of my insurance status, I am ultimately financially responsible for all charges arising for the treatment of myself (or the above named patient, if applicable). If this contract is referred to a collection agency or attorney for collection, I agree to pay all court costs, including attorneys and collection agency fees in the amount of thirty percent (30%) of all total indebtedness due.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Guardian \_\_\_\_\_ Date \_\_\_\_\_



## RGA MISSED APPOINTMENT/ CANCELLATION POLICY

The physicians and staff at Richmond Gastroenterology are here to serve your health care needs in an efficient and timely manner. Last minute cancellations and reschedules severely limits our ability to offer available appointment to other patients in need. We understand that emergencies happen but to best serve all of our patients, we ask that you let us know as soon as possible if you need to cancel or reschedule your visit. RGA reserves the right to limit the number of reschedules for an appointment to ensure equitable access for all patients. RGA may also dismiss patients from the practice if the provider determines the number of reschedules and cancellations is excessive.

As a courtesy, an appointment reminder call to you is made/attempted before your scheduled appointment, but the policy remains in effect regardless of reminder call. Missed appointments or cancellations made **less than 48 business hours** prior to the scheduled appointment will cause you to be billed a cancellation/missed appointment fee in the following amounts. These fees are not covered by Health Insurance; you will be billed directly for these charges. These fees are subject to change based on the needs of the practice.

<b>Endoscopic Procedures</b>	<b>\$250.00</b>
<b>New Patient Office Visit, Telemedicine Visit, or Diagnostic Testing scheduled at RGA</b>	<b>\$100.00</b>
<b>All Other Appointments</b>	<b>\$50.00</b>

**I understand** that I may be charged if I miss my appointment or cancel my appointment per the conditions above. **I understand** this charge is not covered by my insurance and will be my financial responsibility. **I understand** that failure to keep scheduled appointments or provide sufficient notice may result in dismissal from the practice. **I understand** that RGA may limit how many times an appointment can be rescheduled.

Patient's Name (printed)\_\_\_\_\_ Date\_\_\_\_\_

Signature\_\_\_\_\_

\*\*\*\*\*

**Please note:** Due to Medicaid regulations this policy does not apply to patients who are covered by any Medicaid funded health care program accepted by our practice (examples: Medicaid, HealthKeepers Plus, etc). However failure to keep scheduled appointments may result in dismissal from the practice if deemed excessive.

I certify that I am covered by a Medicaid funded program:

Name of Program\_\_\_\_\_

Patient's Name (printed)\_\_\_\_\_ Date\_\_\_\_\_

Signature\_\_\_\_\_

# PATIENT INTERVIEW FORM



Please mark your answers in applicable box.

Patient name: \_\_\_\_\_

Patient date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email address: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Tobacco status:** ☐ Never smoked ☐ Current smoker ☐ Former smoker (Date quit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ ) ☐ Vaping ☐ Chewing tobacco

**Alcohol consumption:** ☐ None ☐ Daily ☐ Weekly ☐ Monthly

**Exercise:** ☐ None ☐ Less than 3/week ☐ 3 or more times/week

**Caffeine intake:** ☐ None ☐ Daily ☐ Weekly

**Drug use:** ☐ Never ☐ Current ☐ Former ☐ Recreational ☐ Intravenous

**Allergies:** ☐ No known allergies ☐ No known drug allergies ☐ Yes (Specify below)

Allergy type: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy type: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy type: \_\_\_\_\_ Reaction: \_\_\_\_\_

**Local pharmacy of choice:** \_\_\_\_\_  
(Name) (Address) (Phone number)

**Mail order pharmacy:** \_\_\_\_\_  
(Name) (Address) (Phone number)

**Current medications including over-the-counter drugs, vitamins and herbs:** (Provide the dose, frequency and reason for taking).

Medication name	Dose	Frequency	Reason for taking

\*If you need additional space for medications, please ask for paper at the check-in desk. If you prefer, we can make a copy of your personal medication list.

## PAST OR PRESENT MEDICAL CONDITIONS

☐ Asthma ☐ COPD/Emphysema ☐ Use Supplemental Oxygen ☐ Tracheotomy ☐ Sleep apnea ☐ Other: \_\_\_\_\_

☐ High blood pressure ☐ A Fib ☐ Congestive heart failure ☐ Heart attack ☐ Cardiac implant/device: \_\_\_\_\_  
Date

☐ Anemia ☐ Arthritis ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High cholesterol ☐ Glaucoma ☐ Organ transplant: \_\_\_\_\_  
Date

☐ Kidney disease: \_\_\_\_\_  
Date ☐ Liver disease: \_\_\_\_\_  
Date ☐ Thyroid disease: \_\_\_\_\_  
Date

☐ Hemorrhoids ☐ Crohn's disease ☐ Colitis ☐ Diverticulitis ☐ Hepatitis: \_\_\_\_\_  
Type

## Previous or Current Infections

☐ COVID-19  
When: \_\_\_\_\_

☐ Tuberculosis  
When: \_\_\_\_\_

☐ Shingles  
When: \_\_\_\_\_

☐ C.Diff  
(Clostridioides difficile)  
When: \_\_\_\_\_

☐ MRSA  
(Methicillin-resistant Staphylococcus aureus)  
When: \_\_\_\_\_

☐ VRE  
(Vancomycin-resistant Enterococci)  
When: \_\_\_\_\_

☐ CRE  
(Carbapenem-resistant Enterobacteriaceae)  
When: \_\_\_\_\_

☐ Hepatitis B  
When: \_\_\_\_\_

☐ Autoimmune Hepatitis  
When: \_\_\_\_\_

**Cardiac Devices** ☐ Pacemaker When: \_\_\_\_\_ ☐ Defibrillator When: \_\_\_\_\_ ☐ AICD When: \_\_\_\_\_

## IMMUNIZATIONS

☐ None
 ☐ Covid-19: \_\_\_\_\_ Year
 ☐ Flu: \_\_\_\_\_ Year
 ☐ Pneumovax: \_\_\_\_\_ Year
 ☐ Hep A: \_\_\_\_\_ Year
 ☐ Hep B: \_\_\_\_\_ Year
 ☐ Zoster: \_\_\_\_\_ Year

Other/Comments: \_\_\_\_\_

## SURGICAL AND PROCEDURAL HISTORY

Surgery/Procedure/Test	Date	Provider/Location
<input type="checkbox"/> None		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> EGD		
<input type="checkbox"/> Other: <input type="checkbox"/> ERCP <input type="checkbox"/> EUS <input type="checkbox"/> Enteroscopy		
<input type="checkbox"/> Manometry or capsule study		
<input type="checkbox"/> CT scan or MRI		
<input type="checkbox"/> Ultrasound		
<input type="checkbox"/> Liver biopsy		
<input type="checkbox"/> Gastric emptying study		
<input type="checkbox"/> UGI/Small bowel follow through		
<input type="checkbox"/> Barium swallow or Enema		
<input type="checkbox"/> Surgery (please specify)		
<input type="checkbox"/> Surgery (please specify)		
<input type="checkbox"/> Surgery (please specify)		

## PERSONAL & FAMILY HISTORY (Check any that apply)

Disease/disorder	Self	Grandparent (s)	Parent(s)	Sibling(s)	Child(ren)	Details
Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (specify type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (specify type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crohns/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems w/ anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## REVIEW OF SYSTEMS

### Cardiovascular

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Palpitations
- ☐ Swelling in hands/feet
- ☐ Syncope
- ☐ Sweats

### Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Loss of appetite
- ☐ Weight gain
- ☐ Weight loss

### ENMT

- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hearing loss

### Endocrine

- ☐ Excessive thirst
- ☐ Heat intolerance

### Eyes

- ☐ Loss of vision

### Gastrointestinal

- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach cramps
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Rectal pain
- ☐ Stool incontinence
- ☐ Vomiting blood

### Genitourinary

- ☐ Discolored urine
- ☐ Painful urination
- ☐ Increased frequency
- ☐ Bloody urine
- ☐ Incontinence

### Hematologic/Lymphatic

- ☐ Easy bruising
- ☐ Prolonged bleeding

### Integumentary

- ☐ Itching
- ☐ Rash
- ☐ Sun sensitivity

### Musculoskeletal

- ☐ Arthritis
- ☐ Back pain
- ☐ Gout
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Stiffness

### Neurological

- ☐ Dizziness
- ☐ Fainting
- ☐ Frequent headaches
- ☐ Memory loss

### Other

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Hallucinations
- ☐ Nervousness
- ☐ Panic attacks
- ☐ Paranoia

### Respiratory

- ☐ Cough
- ☐ Short of breath
- ☐ Wheezing

Check if you have experienced in the last week.

## PATIENT INTERVIEW FORM

Patient name: \_\_\_\_\_

Patient date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Please review and sign the authorizations below. You have the right to refuse to sign. Your refusal will not affect your ability to obtain treatment or payment or eligibility of benefits.
- These authorizations will remain valid for two years of the signature date unless you revoke prior to that time.

(initial in box)

I, ☐ consent ☐ do NOT consent to Richmond Gastroenterology Associates, Inc. obtaining medical records from area hospitals to facilitate my care.

(initial in box)

I, ☐ consent ☐ do NOT consent to Richmond Gastroenterology Associates, Inc. sharing medical information with my PCP and/or referring provider to facilitate my care.

I am aware that Richmond Gastroenterology Associates, Inc. is compliant with the Virginia State Code 18 VAC 76-20-70 and may access medication history information.

I am aware that Richmond Gastroenterology Associates, Inc. encourages the use of our Patient Portal. Through the secure Patient Portal, I am able to communicate with my provider and access, download, and transmit my health information online. I was offered instructions to access the Patient Portal.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## NOTICE OF PRIVACY PRACTICES

Richmond Gastroenterology Associates, Inc. Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice you may obtain a revised copy.

I, \_\_\_\_\_ was offered a copy of Richmond Gastroenterology Associates, Inc. Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions of RGA if I do not understand any information in the Notice of Privacy Practices.

*Print patient name*

Patient signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## OPTIONAL AUTHORIZATION

I, \_\_\_\_\_ hereby authorize Richmond Gastroenterology Associates, Inc. to discuss my Protected Health Information with:

*Print patient name*

_____ <i>Name of relative/friend</i>	_____ <i>Date of birth</i>	_____ <i>Relationship to patient</i>	_____ <i>Contact number</i>
_____ <i>Name of relative/friend</i>	_____ <i>Date of birth</i>	_____ <i>Relationship to patient</i>	_____ <i>Contact number</i>

Patient signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_