New Patient Registration

Last Name:	First Name:	Middle Initial:	
Date of Birth: SSN:	Sex: (Male/Female) Gender at Birth: (Male/Female) Gender Identity: (Male/Female) Sexual Orientation:		
Street Address:		Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	Text: Yes | No
Contact Preference: Home | Cell | Work | Mail | Portal	Hispanic/Latino: Yes | No	Email:	
Marital Status: Married | Single | Divorced | Separated | Widowed | Partner	Language:	Race:	
Occupation:	Employer:	Phone:	
Primary Care Physician:	Specialists:	Preferred Pharmacy: (Name, Street, City, Phone)	
How did you find out about Dr. Malik?			
Emergency Contact:	Relation:	Phone Number:	

Please Fill Out Insurance Policy Holders Information Below (if other than yourself):

Name: _____ Relation: _____

Date of Birth: _____ Address: _____

With whom we may discuss your medical information (non-healthcare providers, family members, friends, etc)?

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

Type of Access: ☐Full ☐Limited _____ Type of Access: ☐Full ☐Limited _____

I hereby authorize Virginia Gastroenterology Institute, PC. to disclose and discuss my protected health information with the persons I have listed on this form. I understand that this consent is voluntary and is not required in order for me to receive treatment. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be covered by these laws and may be re-disclosed by the recipient. I understand that I may revoke this authorization, except to the extent that action has already been taken, at any time by sending written revocation of authorization to Virginia Gastroenterology Institute, PC.

By signing below, I agree that the above information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Form Last Updated: January 2019

Tel: 757.942.2566 • Fax: 855.313.1070
2790 Godwin Blvd, Suite 205, Suffolk, VA 23434-1874 • www.VirginiaGastro.com

Virginia Gastroenterology Institute

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I acknowledge that I have received Virginia Gastroenterology Institute's Notice of Privacy Practices, which describes the ways in which the business may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures.

I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

Name [please print]: _____

Signature: _____

Date: _____

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Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY FORM

REASON FOR VISIT TODAY: _____

ALLERGIES/REACTIONS – Please list any allergies or reactions to medications, foods, latex or dyes. Please list what type of reaction you experienced (example: difficulty breathing, hives, etc)

MEDICATIONS – Please list all your medications and doses. Include vitamins, herbal supplements and over the counter medications (for example: Ibuprofen, Advil, Aleve, Aspirin, Excedrin, Motrin, etc)

Medication	Dosage	How often taken

FAMILY HISTORY OF CANCER – Please list all family history of cancer known (Colon Cancer, Endometrial Cancer, Bile Duct Cancer, Kidney, Ureter or Bladder Cancer, Pancreatic Cancer, Esophageal Cancer, Liver Cancer, Brain Cancer, etc)

Cancer Type	Relation	Age of onset	Age of death

SOCIAL HISTORY – Please circle your responses and fill in the blanks where applicable

What is your occupation: _____
Are you able to care for yourself? YES / NO
Circle One: MARRIED / SINGLE / DIVORCED / SEPARATED / WIDOWED / PARTNER
Are you a current smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:_____
Are you a former smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:_____ Year quit:_____
Do you chew tobacco? YES / NO / Former
Do you drink: YES / RARELY / NO → If yes, please list Amount Per Day _____ OR Amount Per Week _____
Do you currently use recreational drugs? YES / NO
Have you ever used IV drugs? YES / NO
Smokeless Tobacco Status? Never used/Former user/Current user
E-Cigarette/Vape Status? Never used/Former user/Current user

SURGICAL HISTORY : Please list ANY surgeries/procedures and **WHEN** (year it was done) and **WHERE** (location and/or doctor):

Date of Colonoscopy:	**Dr:**	**Date of Upper Endoscopy:**	**Dr:**

Other Surgeries or Procedures:

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY FORM

PAST MEDICAL HISTORY – Please place a checkmark next to the conditions that you have or have had							
	Anemia		COPD		Hepatitis		Pulmonary Embolism
	Anxiety Disorder		Coronary Artery Disease		HIV		Seizures/Epilepsy
	Arthritis		Depression		Hyperlipidemia		Sleep Apnea
	Asthma		Defibrillator		Hypertension		Stroke
	Barrett's esophagus		Diabetes		Hyperthyroidism		Tuberculosis
	Bleeding Disorder		Dialysis		Hypothyroidism		Ulcerative Colitis
	Cancer- list type in other		Diverticulitis/Diverticulosis		Kidney Disease	**Please list any others:**	
	Cirrhosis		GERD/Reflux		Liver Disease		
	Crohn's Disease		Gallstones		Osteoporosis/Osteopenia		
	Colon Cancer		Heart Attack		Pancreatitis		
	Colon Polyps		Heart Disease		Pacemaker		

REVIEW OF SYSTEMS – Please place a checkmark in the box next to the symptoms you have had recently					
Constitutional		**Gastrointestinal**		**Neurologic**	
	Fever		Difficulty swallowing		Weakness
	Chills		Pain on swallowing		Numbness
	Night Sweats		Indigestion/Heartburn		Memory loss
	Weight gain		Bloating		Headaches
	Weight loss		Belching		Dizziness
	Fatigue		Regurgitation	**Psychiatric**	
Ears/Nose/Mouth/Throat/Eyes			Nausea		Confusion
	Earache		Vomiting		Depression
	Ringing in ears		Decreased appetite		Anxiety
	Loss of hearing		Early satiety		Nervousness
	Nose/Sinus issues		Abdominal pain		Insomnia
	Nosebleeds		Diarrhea	**Endocrine**	
	Snoring		Fecal incontinence		Cold intolerance
	Sore Throat		Constipation		Heat intolerance
	Hoarseness		Blood in stool		Excessive thirst
	Mouth sores		Black or tarry stools		Increase in urinary frequency
	Feeling of foreign body in throat		Intolerance to dairy	**Musculoskeletal**	
	Change in Taste		Pain when defecating		Muscle Aches
	Loss of Vision		Rectal pain		Weakness
Cardiovascular			Rectal bleeding		Joint Pain
	Fainting/lightheadedness		Jaundice	**Hematologic/Lymphatic**	
	Chest pain	**Pulmonary**			Bruising
	Palpitations		Cough		Enlarged lymph nodes
	Arm pain on exertion		Coughing up blood		Excessive bleeding
Genitourinary			Shortness of breath	**Other (please list any others)**	
	Prostate enlargement		Wheezing		
	Blood in urine	**Integumentary**			
	Change in urine appearance		Change in skin color		
	Urine incontinence		Rashes or itching		

Signature: It is extremely important that all medical information is disclosed to ensure your complete evaluation. I certify the information on this form is both accurate and complete to the best of my knowledge. No information has been withheld or omitted concerning my past and present state of health.

Signature of patient or guardian:	**Date:**

Form Last Updated: August 2017