Advanced Gastroenterology Associates L.L.C
Homayoon Mahjoob, MD, M.S.P.H
Contact: (301) 352- 7771 Fax: (800) 681-5070

REGISTRATION FORM

Today's date:	**Primary Care Physician:** Primary Care Physician Phone#: Fax#

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:		Marital Status (circle one) Single/Mar/Div/Sep
Legal Name (if different from above):	Former Name (If applicable):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street Address:		City:	State:	Zip code:
Social Security #:	Home #:	Cell#	Email Address:	
Occupation:	Employer:	Employer Address:		Employer Phone#:

Referred by: ❑ Physician, Name:__________________ ❑ Hospital ❑ Family ❑ Internet/Directory

Phone:__________________ ❑ Insurance Plan ❑ Friend ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )
Is this person a patient here?	❑ Yes ❑ No		
Occupation:	Employer:	Employer address:	Employer phone#: ( )
Is this patient covered by insurance? ❑ Yes ❑ No	Please indicate primary insurance Name:		

Subscriber's name:	Subscriber's SSN	Birth date: / /	Policy #:	Group #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other				

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone#:	Work phone#:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced GI Associates LLC or insurance company to release any information required to process my claims. **Please note you will receive only one statement for any patient balance due. If not paid within 30 days, the account will be considered for collections and associated fees unless arrangements have been made with our office.**

_______________________________________ ________________

Patient/Guardian signature ***Date***

MEDICAL HISTORY

YES	NO	HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?	IF YES, PLEASE EXPLAIN DISEASE AND TIME OF DIAGNOSIS
		Diabetes	
		High Blood Pressure	
		Abnormal Cholesterol	
		Stroke	
		Heart Disease	
		Lung Disease	
		Kidney Diseases	
		Gastrointestinal Diseases	
		Liver Diseases	
		Pancreas Diseases	
		Gallbladder Diseases	
		Colon Polyps	
		Musculoskeletal/Joint Diseases	
		Vascular Diseases (blood vessels)	
		Cancer	
		Hepatitis A, B, or C	
YES	**NO**	**ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?**	**PLEASE EXPLAIN WHEN IT BEGAN AND HOW OFTEN IT OCCURS**
		Eyes: Jaundice/Double vision	
		Ear, Nose & Throat: Sore throat/ Nasal congestion	
		Respiratory: shortness of breath/Cough/Phlegm/Wheezing/Blood in sputum	
		Cardiovascular: Chest pain/Palpitation/Irregular heart beat/Calf pain/Pain when walking/Leg swelling (edema)	
		Skin: Rash/Abrasions/Discoloration	
		Neurologic: Tingling/Abnormal balance	
		Psychiatric: Anxiety/Depression/Mania/Suicidal/Delusional/ Hallucination	
		Gastrointestinal and Constitutional	
		Significant weight loss/gain	
		Eating Disorders	
		Difficulties Swallowing	
		Painful swallowing	
		Regurgitation	
		Heartburn	
		Nausea	
		Vomiting	
		Vomiting Blood	
		Abdominal Pain	
		Abdominal Bloating/Swelling	
		Diarrhea	
		Constipation	
		Blood in stool	
		Change of color in stool	
		Rectal Itching	
		Painful/bleeding hemorrhoids	
		Are you having Regular Bowel Movements?	
		Other GI symptoms not listed?	

PLEASE LIST ALL PAST HOSPITALIZATIONS AND SURGERIES:	DATE:

PAST PROCEDURE HISTORY: Have you had any of the following?	YEAR(S) DONE:	WHAT WERE THE FINDINGS:
Colonoscopy Yes ☐ No ☐		
Upper Endoscopy Yes ☐ No ☐		
ERCP Yes ☐ No ☐		

Social History

Do you drink alcohol? ☐Yes ☐No

If Yes, How often? ____________________

Do you smoke? ☐Yes ☐No

If Yes, How often? ____________________

If No, are you a former smoker?
☐Yes ☐No

Do you use illicit drugs? ☐Yes ☐No

If Yes, How often? ____________________

ALLERGIES: Do you have any allergies? ☐Yes ☐No	
If yes, please list all allergies including medication, food, and environmental:	Description of allergic reaction:

MEDICATIONS		
Please list all CURRENT MEDICATIONS:	Dose:	Reason:

Question		
Are you currently taking any Aspirins?	☐Yes	☐No
Are you currently taking any Non steroidal antinflammatory drugs (Naproxen, Motrin, Ibuprofen, Aleve)	☐Yes	☐No
Are you currently taking any blood thinners/anticoagulants? (Plavix, Heparin, Warfarin, Xarelto, Effient)	☐Yes	☐No

PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Phone #: (   )_____________

Pharmacy Address: Street: ______________________
City:_________________ Zip: ____________

Please list all DISCONTINUED medications	Dose:	Reason:

FAMILY HISTORY: please check all that apply:			
Family History of Colon Cancer:	☐Yes	☐No	If Yes, Who:
Family History of Colon Polyps:	☐Yes	☐No	If Yes, Who:
Family History of Pancreas, Liver, Gallbladder, Stomach, Esophagus, Intestinal diseases:	☐Yes	☐No	If Yes, Who:
Other Family History such as other cancers/diseases:	☐Yes	☐No	If Yes, What and Who:

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Consent for Release and Use of Confidential Information

I, _____________________________, hereby give my consent to Advanced GI Associates LLC., to
(Name of Patient or Authorized Agent)

Disclose for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _________________________(Name of Patient).
I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relined on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office. I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Printed Name of Patient or Authorized Agent: _______________________

Signed:________________________ Date:____________

If not the patient, please specify your relationship to the patient: _________________________