Northern Virginia Endoscopy Center
Gastroenterology

Houshang Makipour, MD, AGAF
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Patient Demographics

Please PRINT all information in spaces provided.

Patient Information			
Last Name:	Frist Name:		M. I:
Home Address:			
City:		State:	Zip Code:
Date of Birth:	Age:	SSN:	Sex: M F
Cell Phone No.:		Home Phone No.:	
Work Phone No.:		Email:	
How did you hear about us (circle one) : PCP INSURANCE INTERNET OTHER:_____			

Employer Information
Employer Name:
Employer's Address:

Emergency Contact		
Contact Name:	Phone No.:	Relationship:

Ethnicity:

Alaska Native / American Indian
Black / African American
Native Hawaiian /Pacific Islander
White / Caucasian
Hispanic
Other: _____

Ethnic Group: Hispanic/ Latino Non- Hispanic/ Latino

Primary Insurance	Secondary Insurance
Primary Insurance Name	Secondary Insurance Name
Policy No.	Policy No.
Group No.	Group No.
Policy Holder Name	Policy Holder Name
Relationship to patient:	Relationship to patient:
Policy Holder Date of Birth : Sex: M F	Policy Holder Date of Birth : Sex: M F

I hereby authorize payment of medical benefits billed to my insurance to Houshang Makipour, MD, PC. I hereby accept responsibility for payment for any service/s provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance. If the practice does not participate with my insurance, I understand that I am responsible for obtaining and tracking my referrals if one is necessary for my insurance. I agree to pay all co-payments, co-insurance and deductibles at the time of services are rendered. In the event my account is turned over to an attorney for collections, I will pay any fee/cost incurred during the collection process.

Signature: _____ **Date:** _____

Last Name: _____ First Name: _____

Date of Birth: _____ Marital Status: Single Married Divorced Widow/er

Primary Care Physician: _____ Pharmacy Name & No. _____

PAST MEDICAL HISTORY:

Please list any medical conditions you may have: _____

Have you ever had a Colonoscopy? ___ No ___ Yes If Yes, when? _____

Have you ever had problems with anesthesia ? ____ No ____Yes Please Explain _____

Are you allergic to any medications? ___ No ___ Yes_____**Name** of medication:_____ Type of reaction_____

Are you or have you ever used any recreational/illegal drugs? ___ No ___ Yes How Long: _____

Date last used: _____ What kind: _____

Have you ever used any *tobacco* or *alcohol* products? ___ No Yes

Alcohol: How many drinks per day _____Per week _____or Per Month _____

Tobacco: How many Cigarettes per day _____ Per week _____Per Month _____ How many years? _____

REVIEW OF SYSTEMS: Have you currently or previously been diagnosed with any of the following?

Gastrointestinal		**Cardiac**		**Neurologic**		**ENT**	
Diarrhea	_____	Hypertension	_____	Seizures	_____	Loose Teeth	_____
Constipation	_____	Hypotension	_____	Weakness	_____	Nose Bleeds	_____
Rectal Bleeding	_____	Irregular Heart Beat	_____	Migraines	_____	Deafness	_____
Change in BM's	_____	Chest pains	_____	Previous Stroke	_____	**Psychosocial**	
Weight loss	_____	CABG	_____	**Musculoskeletal**		Alcoholism	_____
Abdominal Pain	_____	Atrial Fibrillation	_____	Fibromyalgia	_____	Substance Abuse	_____
Regurgitation	_____	**Respiratory**	_____	Lupus	_____	Depression	_____
Heart Burn	_____	Asthma	_____	Muscle Disease	_____	Anxiety	_____
Trouble swallowing	_____	Pneumonia	_____	Arthritis	_____	**Breast**	
Nausea	_____	Bronchitis	_____	Neck Pain	_____	Lumps	_____
Vomiting	_____	Chronic cough	_____	Back Pain	_____	Breast Cancer	_____
Irritable Bowel	_____	Hoarseness	_____	Blood Disorder	_____	**Endocrine**	
Polyps	_____	Tracheostomy	_____	Gout	_____	Diabetic	_____
Hepatic	_____	**Genitourinary**	_____	Bruises	_____	Hyperthyroid	_____
Liver Disease	_____	Kidney Disease	_____	**Ophthalmic**		Hypothyroid	_____
Hep A, B or C	_____	Frequent UTI	_____	Cataracts	_____		
Yellow Skin	_____			Glaucoma	_____		
Pancreatitis	_____			Blindness	_____		

FAMILY HISTORY: Please check YES or NO, Along with your relation

Colon/Rectal Cancer	No	Yes	Relation:	Colon Polyps	No	Yes	Relation:
Heart Disease	No	Yes	Relation:	Ulcerative Colitis	No	Yes	Relation:
Stomach Cancer	No	Yes	Relation:	Crohns Disease	No	Yes	Relation:
Breast Cancer	No	Yes	Relation:	Ovarian Cancer	No	Yes	Relation:
Bleeding Problems	No	Yes	Relation:				

Surgeries	Month/Year	**Hospitalizations**	Month/Year

Medications: Please List	Dose	Frequency	**Medications:** Please List	Dose	Frequency

Patient Signature: _____ Date: _____

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). HIPPA generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI Disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient.

Uses and disclosures for PHI may be permitted without prior consent in an emergency. HIPPA also allows disclosure to other physicians for continuity of care without prior consent from the patient.
All authorizations will be in effect until revoked in writing by the patient.

I wish to allow the following persons access to my medical records and permission for Dr. Makipour or his staff to speak to who I choose about my medical care for the time specified:

Name	**Relationship to patient**
_____	_____
_____	_____
_____	_____

Duration of access: **Present through** ____/____/____ _____ **Lifetime**

Access to:

_____ Entire Record _____ Office Notes Only

_____ Laboratory/Radiology Results Only _____ Procedure Results Only

I acknowledge that I have received the following disclosures from the practice:

- Facility Information
- Patient Bill of Rights
- Complaint Resolution Policy
- Billing Information
- Information of Pain Assessment
- Notice of Privacy Practices (HIPPA)
- Physician Qualification
- Medication Reconciliation Consent

Printed Name _____ **Date** _____

Signature _____

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PROCEDURE CANCELLATION

A **$500.00** fee will be billed to patients for failure to cancel any scheduled procedure at least **5 business days prior**. This is not billable to insurance.

OFFICE VISIT CANCELLATION

Office visit appointments not canceled within 24 hours may result in no further appointments being scheduled.

MEDICAL RECORDS

There is a **$25.00** fee for any medical records requests, plus **.50¢** per page.
There is an additional $10 charge if you would like your records to be mailed.

FORMS /LETTERS

Forms: $25.00 for the first page and $5 for each additional page.

LOST PRESCRIPTIONS/ORDERS

Lost order/prescriptions: There is a **$10.00** fee for the first, and $5 for each additional

CHECKS

There is a **$50.00** for checks returned for non sufficient funds
We do not accepts checks in the office

Signature _____ . **Date** _____ .