GANV
GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA

REGISTRATION FORM

PLEASE PRINT

For Office Use Only
Procedure Date_____ Time_____
Location _____
Physician _____

Patient: (Mr., Mrs., Ms., Dr.) Last Name _____First Name _____M.I_____Email_____

Social Security # _____ (***Required*** for insurance billing purposes. May omit if choose to self-pay)

Date of Birth _____Age_____ Sex: Male ☐ Female ☐

Street _____City _____State _____Zip_____

Home Tel. # _____Business Tel.# _____Ext. _____Cell # _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Employer _____

Race: ☐ Caucasian ☐ Hispanic ☐ Non-Hispanic ☐ Asian ☐ Black or African-American ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Island ☐ Decline response

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Person responsible for your account: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other _____
Please complete if other than self:

Name _____ Soc. Sec. # _____ D.O.B.: _____

Address _____City _____State _____Zip_____

Employer _____Bus. # _____Home #: _____

REFERRING PHYSICIAN

Name: _____
City: _____
State: _____Zip: _____
Phone: ( ) _____

PRIMARY CARE PHYSICIAN If different than referring Physician

Name: _____
City: _____
State: _____Zip: _____
Phone: ( ) _____

How did you hear about GANV?

☐ Physician Referral ☐ Angie's List
☐ Friend or Family ☐ Mailing
☐ Internet Search ☐ Community Program
☐ Insurance Company
☐ Ad In _____
☐ Other _____

INSURANCE INFORMATION

Please indicate if you belong to a PPO ☐ HMO ☐

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Ins. Co. Name _____

I.D.#: _____S.S.#: _____

Insurance Address: _____

_____

Group #: _____Group Name: _____

Policy Holder_____Relation _____

Sex: ☐ M ☐ F Date of Birth: _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Ins. Co. Name _____

I.D.#: _____S.S.#: _____

Insurance Address: _____

_____

Group #: _____Group Name: _____

Policy Holder_____Relation _____

Sex: ☐ M ☐ F Date of Birth: _____

IN CASE OF EMERGENCY

Name _____Relationship _____Phone: _____

WAIVER:

I _____, agree to be seen by
PLEASE PRINT
_____ , M.D. on
_____

I acknowledge that I did not bring a referral as required by my insurance company or do not have my insurance card. I am electing to be seen today and agree to pay today for services rendered since I do not have a valid referral or insurance card.

_____
SIGNED DATE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s).

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNED (patient or Parent if Minor) DATE
In order to schedule your procedure all registration and consent forms MUST be signed.