

**GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA, LTD.**

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**PLEASE PRINT**

**Patient:** (Mr., Mrs., Ms, Dr.) Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_  
 Social Security # \_\_\_\_\_ 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 \_\_\_\_\_

**Patient:** Who will be responsible for your account?  Self  Spouse  Father  Mother  Other  
 Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Bus. # \_\_\_\_\_ Home #: \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: ( ) _____	Phone: ( ) _____

**INSURANCE INFORMATION**

Patient: Student: Full Time  Part Time  Not  School Name/Address \_\_\_\_\_  
 Married  Divorced  Legally Separated  Widow  Single  \_\_\_\_\_  
 Employed: Full Time  Part Time  Retired  Not  Do you belong to a PPO  HMO

**PRIMARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Ins. Co. Name \_\_\_\_\_  
 I.D.#: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
 Plan \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth: \_\_\_\_\_  
 Address \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE COMPANY**

Employer \_\_\_\_\_  
 Ins. Co. Name \_\_\_\_\_  
 I.D.#: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
 Plan \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relation \_\_\_\_\_  
 Sex:  M  F Date of Birth: \_\_\_\_\_  
 Address \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_  
 Nearest Living Relative or Friend not living with you. \_\_\_\_\_ Relative/Friend Phone \_\_\_\_\_

**WAIVER:**

I \_\_\_\_\_, agree to be seen by  
 \_\_\_\_\_, 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.

\_\_\_\_\_ DATE \_\_\_\_\_  
 SIGNED (patient or Parent if Minor) \_\_\_\_\_ DATE \_\_\_\_\_