

**Adult
Patient Registration**

GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA, LTD.

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PATIENT NUMBER		LOCATION		DOCTOR		PATIENT SHOULD COMPLETE WHITE AREAS ONLY	
LAST NAME				FIRST NAME & INITIAL			
ADDRESS:							
CITY:					STATE:		ZIP:
HOME PHONE ()			DATE OF BIRTH:			SEX:	
MARITAL STATUS (M/S):							
S.S. NO.				EMPLOYER:			
EMPLOYER ADDRESS:							
CITY:					STATE:		ZIP:
EMPLOYER PHONE ()				EXT.		PATIENTS OCCUPATION:	
PRIMARY CARE PHYSICIAN:				REFERRING PHYSICIAN:			
NAME:				NAME:			
ADDRESS:				ADDRESS:			
CITY:		STATE:		ZIP:		CITY:	
PHONE ()				PHONE ()			
PRIMARY INSURANCE COMPANY (#1):						HOW LONG?	
ADDRESS:						PHONE ()	
POLICYHOLDER LAST NAME:				FIRST NAME:		RELATIONSHIP:	
CERTIFICATE NO.:				GROUP NO.:			
SECONDARY INSURANCE CARRIER (#2):						HOW LONG?	
ADDRESS:						PHONE ()	
POLICYHOLDER LAST NAME:				FIRST NAME:		RELATIONSHIP:	
CERTIFICATE NO.:				GROUP NO.:			
SPOUSE'S NAME:						SPOUSE'S WORK 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.

SIGNED (Patient or Parent if Minor) _____ DATE _____