Gastroenterology Specialists of Gwinnett, P.C.

PATIENT REGISTRATION

Dr. Jennifer A. Curtis DATE: ______________ Patient Account Number: ____________________

PATIENT INFORMATION

PATIENT'S NAME: ____________________ SEX: M __ F __ AGE: ___ DATE OF BIRTH: ______________

ADDRESS: ______________________________ CITY: ___________ STATE: ____ ZIP: ___________

HOME PHONE: ________________ CELL / PAGER: ____________ SOC SEC #: ____________________

EMPLOYER: ____ WORK #: ______________________

ADDRESS: ____________________________ CITY: ______________ STATE: ____ ZIP: ___________

SPOUSE'S NAME: __________________ DATE OF BIRTH: ____________ SOC SEC #: ________________

EMPLOYER: ______________________________________ WORK #: _________________________

ADDRESS: ____________________________ CITY: ______________ STATE: ____ ZIP: ___________

PRIMARY INSURANCE INFORMATION

POLICY HOLDER: ___________________________ PATIENT I.D. #: ___________________________

POLICY HOLDER D.O.B.: _____________________ RELATIONSHIP TO PT: _______________________

INSURANCE CO. NAME: ___________________________ CUSTOMER SERVICE #: ________________

SECONDARY INSURANCE INFORMATION

POLICY HOLDER: ___________________________ PATIENT I.D #: ___________________________

POLICY HOLDER D.O.B.: _____________________ RELATIONSHIP TO PT: _______________________

INSURANCE CO. NAME: ______________________________ CUSTOMER SERVICE #: ______________

**PRIMARY CARE PHYSICIAN ** **REFERRING PHYSICIAN **

NAME: _______________ PHONE #: ___________ NAME: _______________ PHONE: ___________

EMERGENCY CONTACT INFORMATION-(Someone not living with you)

NAME: _________________________ RELATIONSHIP: ______________ CONTACT #: ______________

I authorize Gastroenterology Specialists of Gwinnett to release all information necessary to facilitate the processing of all claims related to my care. I authorize use of this signature on all my insurance submissions. I understand I am financially responsible for all charges for office visits and procedures: my insurance deductible, co-payment, and co-insurance, and any balance not paid by my insurance company. I understand that in the event that endoscopy procedures are performed, either at Northeast Endoscopy Center or at Gwinnett Medical Center, that a facility fee will be charged and that any deductibles, copays, etc which may apply are my responsibility. Any amount not paid by insurance is due in full within 30 days of the insurance payment. I understand that I am responsible for <u>all</u> charges whether or not paid by insurance, including any collection fees, attorney fees, court costs, etc. should account be turned over to collections.

____ ____________________

Signature of Patient (or parent, if minor) Date

I have been given the opportunity to review the Notice of Privacy Practices.

____ ____________________

Signature of Patient (or parent, if minor) Date

**** MUST BE FILLED OUT TO PROCESS CLAIM****

Gastroenterology Specialists Of Gwinnett, P.C.

Zack Z. Martin, M.D. D. Brad Lord, M.D. W. Gordon Tanner, Jr. M.D. Jae W. Nam, M.D. Jennifer A. Curtis, M.D.

Personal History

Patient Name: ______________________________

Referred By: ____________________ Primary Care Physician: ____________________

History of Illness:

Please describe the problem(s) you are having: ______________________________

____

____

Please list all past surgeries, hospitalizations, significant medical illnesses, and cancers:

____

____

____

____

____

Medications - including herbal and vitamins:

Name of Med

____

____

____

____

____

____

____

Please circle any of these medicines that you have tried:

Zantac ; Tagamet ; Pepcid ; Axid ; Prevacid ; AcipHex ; Prilosec ; Protonix

Drug Allergies:

Name of Medication:

____

____

____

____

Social History:

Give details regarding current and past use of (estimate daily or weekly usage):

Alcohol: Amount ______________________________

Tobacco: Amount ______________________________

Family History (Blood Relative):

Is there a history of colon cancer/polyps? Y N Who: ____________________

721 Wellness Way N.W., Suite 100 • Lawrenceville, Georgia 30045 • (770)995-7989 • (770) 995-3113
3855 Pleasant Hill Rd., Suite 230 • Duluth, Georgia 30096 • (770) 495-8300

Patient Name: ______________________

Review of Systems and Symptoms:

Check each box that applies, and explain to the right to accurately describe your symptoms.

Yes No

Constitutional

- ☐ ☐ Weight loss
- ☐ ☐ Fever
- ☐ ☐ Fatigue
- ☐ ☐ Weakness
- ☐ Other ______________________

Ear, Nose, Mouth, Throat

- ☐ ☐ Hearing loss
- ☐ ☐ Ear Pain/Ringing
- ☐ ☐ Mouth ulcers or Sores
- ☐ ☐ Poor Dentition
- ☐ ☐ Nose Bleeds
- ☐ ☐ Difficulty in Swallowing
- ☐ Other ______________________

Eyes

- ☐ ☐ Glaucoma
- ☐ ☐ Vision Loss
- ☐ Other ______________________

Lungs

- ☐ ☐ Shortness of Breath
- ☐ ☐ Asthma/Wheezing/Cough
- ☐ Other ______________________

Genitourinary

- ☐ ☐ Are you pregnant?
  Date of last period ____________
- ☐ ☐ Recent/Frequent Urinary Tract Infection
- ☐ ☐ Blood in Urine
- ☐ ☐ Burning with Urination
- ☐ ☐ History of Kidney Stones
- ☐ Other ______________________

Musculoskeletal

- ☐ ☐ Lupus, Scleroderma, Related Disease
- ☐ ☐ Joint Pain/Arthritis
- ☐ ☐ Back Pain
- ☐ Other ______________________

Skin

- ☐ ☐ Dermatitis or Rash
- ☐ ☐ Itching
- ☐ ☐ Psoriasis
- ☐ Other ______________________

Allergic/Immunologic

- ☐ ☐ HIV/AIDS

Yes No

Abdominal

- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Heartburn/Esophageal Reflux
- ☐ ☐ Nausea/Vomiting
- ☐ ☐ Hiatal Hernia
- ☐ ☐ Indigestion
- ☐ ☐ Bloating/Belching/Gaseousness
- ☐ ☐ Abdominal Pain
- ☐ ☐ Peptic Ulcer
- ☐ ☐ Gallstones/Gallbladder Disease
- ☐ ☐ Hepatitis or Liver Disease
- ☐ ☐ Crohn's Disease/Ulcerative Colitis
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Gastrointestinal Bleeding
- ☐ ☐ Hemorrhoids
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea/Loose Stool
- ☐ ☐ Change of Bowel Habit
- ☐ Other ______________________

Heart

- ☐ ☐ Chest pain
- ☐ ☐ Pacemaker
- ☐ ☐ History of Heart Attack
- ☐ ☐ Mitral Valve Prolapse or Murmur
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Hypertension
- ☐ Other ______________________

Neurological

- ☐ ☐ Seizure Disorder
- ☐ ☐ Headache
- ☐ ☐ Stroke
- ☐ Other ______________________

Psychiatric

- ☐ ☐ Depression or Anxiety
- ☐ ☐ Past Evaluation or Treatment
- ☐ Other ______________________

Endocrine

- ☐ ☐ Thyroid Disease
- ☐ ☐ Diabetes
- ☐ Other ______________________

Hematologic/Lymphatic

- ☐ ☐ Enlarged Nodes or Swollen Glands
- ☐ ☐ Anemia
- ☐ ☐ Bleeding Problems
- ☐ Other ______________________

Physician Signature: ______________________ Date: ____________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

__ Home Telephone ____________________

- __ O.K. to leave message with detailed information
- __ Leave message with call-back number only

__ Written Communication

- __ O.K. to mail to my home address
- __ O.K. to mail to my work/office address

__ Work Telephone ____________________

- __ O.K. to leave message with detailed information
- __ Leave message with call-back number only

__ Other ____________________

____

I give my permission to discuss my healthcare with: ____________________

____

Relationship to Patient: ____________________

____________________ Patient Signature

____________________ Date

____________________ Print Name

____________________ Birthdate

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	