Gastroenterology Specialists of Gwinnett, P.C.

PATIENT REGISTRATION

Dr. Zack Z. Martin 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 all 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.

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	