GASTROENTEROLOGY SPECIALISTS OF GWINNETT, P.C.
PATIENT REGISTRATION

PROVIDER:_____ DATE:_____

PATIENT ACCOUNT NUMBER:_____

PATIENT'S NAME:_____ SEX: M___F___DATE OF BIRTH:_____

RACE:_____ETHNICITY:_____LANGUAGE:_____SSN:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____
EMAIL:_____
PHARMACY NAME:_____PHARMACY #:_____
EMPLOYER:_____
SPOUSE'S NAME:_____DATE OF BIRTH:_____SSN:_____
HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

PRIMARY INSURANCE INFORMATION
INSURANCE CO. NAME:_____CUSTOMER SERVICE #:_____
ID#:_____GROUP#:_____
POLICY HOLDER:_____DATE OF BIRTH:_____
RELATIONSHIP TO PT:_____

SECONDARY INSURANCE INFORMATION
INSURANCE CO. NAME:_____CUSTOMER SERVICE#:_____
ID#:_____GROUP#:_____
POLICY HOLDER:_____DATE OF BIRTH:_____
RELATIONSHIP TO PT:_____

PRIMARY CARE PHYSICIAN
NAME:_____
PHONE#:_____

REFERRING PHYSICIAN
NAME:_____
PHONE #:_____

EMERGENCY CONTACT (SOMEONE NOT LIVING WITH YOU)
NAME:_____ PHONE#:_____
RELATIONSHIP:_____

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 of my insurance submissions. I understand I am financially responsible for all charges for office visits and procedures including any deductibles, 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 Gwinnett Medical Center, that a facility fee will be charged and that any deductibles, copays, co-insurance, etc. which may apply are my responsibility. Any amount not paid by my 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 collections fees, attorney fees, court costs, etc. should my account be turned over to collections. We assess a $30.00 fee for returned checks and a fee for collection action.**

_____ _____
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

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

____Work 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

____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

DATE:_____

NAME:_____ DOB:_____

What PRESCRIPTION medications are you taking at this time?

Name of Medication	Dosage	Frequency

What OVER-THE-COUNTER medications are you taking?
(ex. Aspirin, Motrin, Tagamet-HB, Vitamins, etc.)

Name of Medication	Dosage	Frequency

MEDICATION ALLERGIES
Please list the medications or injections that have given you bad reactions. If possible, include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath).
