



www.gigeorgia.com

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Dear Patient,

Thank you for choosing GI Specialists of Georgia for your healthcare needs. We are looking forward to welcoming you to our practice.

Enclosed you will find patient information and medical history forms that will **need to be completed and brought to the office at the time of your appointment. Failure to complete these forms prior to your arrival at the facility may delay your appointment.** We also require a list of any medications you are taking, including dosage.

We accept and file most major insurances, including Medicare. Please bring your insurance card(s) with you so that we can create your record in our system and assist you with your insurance. If you have an outstanding balance or your insurance requires a deductible or co-payment, this will be collected at the time of your appointment.

Again, thank you for choosing GI Specialists of Georgia for your healthcare needs. We will strive to make your relationship with us as pleasant as possible.

Physicians and Staff  
GI Specialists of Georgia

Enclosures

# Gastrointestinal Specialists of Georgia, PC

## PATIENT INFORMATION SHEET

FIRST NAME _____ MI _____ LAST NAME _____
ADDRESS _____ EMAIL _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
CELL PHONE _____ DATE OF BIRTH (mm/dd/yyyy) _____
SOCIAL SECURITY # _____ SEX: M ___ F ___ RACE _____
ETHNICITY _____ MARITAL STATUS: S ___ M ___ D ___ W ___
EMPLOYER NAME _____ OCCUPATION _____
EMPLOYER ADDRESS _____
<b>(1) PRIMARY INSURANCE</b> _____
ID# _____ GROUP NAME/NUMBER _____
POLICY HOLDER'S FULL NAME _____
POLICY HOLDER'S RELATIONSHIP TO THE PATIENT _____
POLICY HOLDER'S DOB (m/dd/yyyy) _____ POLICY HOLDER'S SSN _____
<b>(2) SECONDARY INSURANCE</b> _____
ID# _____ GROUP NAME/NUMBER _____
POLICY HOLDER'S FULL NAME _____
POLICY HOLDER'S RELATIONSHIP TO THE PATIENT _____
POLICY HOLDER'S DOB (m/dd/yyyy) _____ POLICY HOLDER'S SSN _____
Who referred you: _____
Who is your Primary Care Physician: _____
Pharmacy Name _____ Pharmacy Phone _____
Nearest relative not living with you in case of emergency _____
Relation _____ TEL # _____

**If you are unable to keep your appointment, please call our office. Failure to do so will result in a \$20 charge being billed to you.**

# GASTROINTESTINAL SPECIALISTS OF GEORGIA, PC

## Patient History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

Race/Ethnicity (Medicare Required): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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**MEDICATIONS:** Are you on any of these medications?

- |  |   |   |
|--|---|---|
| <input type="radio"/> Aspirin            | <input type="radio"/> Plavix/other blood thinners | <input type="radio"/> Arthritis Medications |
| <input type="radio"/> Ibuprofen Products | <input type="radio"/> Coumadin/Warfarin           | <input type="radio"/> Insulin               |

Please list all your medications and dosages (or provide a separate list if you prefer):

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**ALLERGIES:**  None  Latex  Iodine  Others (please list): \_\_\_\_\_

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**CURRENT SYMPTOMS / ILLNESSES:** Mark all that apply

- |  |  |
|--|--|
| <input type="radio"/> Heartburn                        | <input type="radio"/> Diarrhea                     |
| <input type="radio"/> Trouble swallowing               | <input type="radio"/> Change in bowel habits       |
| <input type="radio"/> Painful swallowing               | <input type="radio"/> Bloody stools                |
| <input type="radio"/> Nausea                           | <input type="radio"/> Weight loss/Lack of appetite |
| <input type="radio"/> Vomiting                         | <input type="radio"/> Anemia                       |
| <input type="radio"/> Abdominal Pain                   | <input type="radio"/> Liver problems               |
| <input type="radio"/> Bloating, Distention, Excess Gas | <input type="radio"/> Gallbladder problems         |
| <input type="radio"/> Constipation                     | <input type="radio"/> Pancreas problems            |

Other: \_\_\_\_\_

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Anesthesia Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

**MEDICAL HISTORY:** Please fill in circles completely and write in additional comments

	<u>Year &amp; Comment</u>		<u>Year &amp; Comment</u>
<input type="radio"/> History of colon cancer	_____	<input type="radio"/> Hypertension	_____
<input type="radio"/> History of colon polyps	_____	<input type="radio"/> Heart attack or Heart disease	_____
<input type="radio"/> Reflux disease	_____	<input type="radio"/> Stroke	_____
<input type="radio"/> Barrett's esophagus	_____	<input type="radio"/> High cholesterol	_____
<input type="radio"/> Crohn's disease	_____	<input type="radio"/> Lung disease	_____
<input type="radio"/> Ulcerative Colitis	_____	<input type="radio"/> Diabetes	_____
<input type="radio"/> Anemia	_____	<input type="radio"/> Cancer history	_____
<input type="radio"/> Hepatitis	_____	<input type="radio"/> Psychiatric disorder	_____
<input type="radio"/> Other Liver disease	_____	<input type="radio"/> Arthritis	_____
<input type="radio"/> Irritable Bowel Syndrome	_____	<input type="radio"/> Thyroid disease	_____

Please list any other pertinent medical problems: \_\_\_\_\_

**PAST SURGICAL HISTORY:** Please fill in circles completely and write in additional comments

	<u>Year &amp; Comment</u>		<u>Year &amp; Comment</u>
<input type="radio"/> Gallbladder surgery	_____	<input type="radio"/> Coronary stent / Bypass surgery	_____
<input type="radio"/> Stomach surgery	_____	<input type="radio"/> Heart valve surgery	_____
<input type="radio"/> Colon surgery	_____	<input type="radio"/> Pacemaker / Defibrillator	_____
<input type="radio"/> Other abdominal surgery	_____	<input type="radio"/> Thyroid surgery	_____
<input type="radio"/> Hemorrhoidectomy	_____	<input type="radio"/> Hernia repair	_____

Other Surgeries: \_\_\_\_\_

**SOCIAL HISTORY:** Please fill in circles completely and write in additional comments

<u>Alcohol use:</u>	<u>Tobacco use:</u>	<u>Illicit Drug use:</u>	<u>Have you ever had:</u>
<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> Never	<input type="radio"/> Tattoo
<input type="radio"/> <1 Drink/day	<input type="radio"/> Less than 1/2 pack/day	<input type="radio"/> Past Experimentation	<input type="radio"/> Blood Transfusion
<input type="radio"/> 1-2 Drinks/day	<input type="radio"/> 1 pack/day	<input type="radio"/> Former Use	
<input type="radio"/> 3 or more drinks per day	<input type="radio"/> More than 1 pack/day	<input type="radio"/> Recent/Active Use	
<input type="radio"/> Former alcohol use	<input type="radio"/> Former tobacco use	Type of Drug: _____	

**Married :**  Yes  No      **Children:**  Yes  No      How Many? \_\_\_\_\_      **Occupation:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Fill in ALL of the following you have experienced over the last year. Fill in circle completely :

- |            |                            |                                     |   |  |  |
|------------|----------------------------|-------------------------------------|---|--|--|
| HEENT:     | <input type="radio"/> None | <input type="radio"/> nosebleeds    | <input type="radio"/> sinus/postnasal drip      | <input type="radio"/> ringing in ears          | <input type="radio"/> sore throat        |
| DERM:      | <input type="radio"/> None | <input type="radio"/> skin rash     | <input type="radio"/> skin itching              | <input type="radio"/> skin sores               | <input type="radio"/> hair loss          |
| OPHTHO:    | <input type="radio"/> None | <input type="radio"/> vision change | <input type="radio"/> eye pain/redness          | <input type="radio"/> double vision            | <input type="radio"/> jaundice           |
| DENTAL:    | <input type="radio"/> None | <input type="radio"/> oral ulcers   | <input type="radio"/> bleeding gums             | <input type="radio"/> hoarseness               | <input type="radio"/> bad breath         |
| PULM:      | <input type="radio"/> None | <input type="radio"/> chronic cough | <input type="radio"/> shortness of breath       | <input type="radio"/> asthma/wheezing          | <input type="radio"/> cough up blood     |
| CARDIAC:   | <input type="radio"/> None | <input type="radio"/> chest pain    | <input type="radio"/> irregular heartbeat       | <input type="radio"/> rapid heart rate         | <input type="radio"/> palpitations       |
| URINARY:   | <input type="radio"/> None | <input type="radio"/> bloody urine  | <input type="radio"/> frequent urination        | <input type="radio"/> difficulty urinating     | <input type="radio"/> painful urination  |
| GYN:       | <input type="radio"/> None | <input type="radio"/> pelvic pain   | <input type="radio"/> heavy vaginal bleeding    | <input type="radio"/> abnormal discharge       | <input type="radio"/> irregular menses   |
| MUSC/SKEL: | <input type="radio"/> None | <input type="radio"/> leg cramps    | <input type="radio"/> pain with movement        | <input type="radio"/> muscle/joint pains       | <input type="radio"/> low back pain      |
| NEURO:     | <input type="radio"/> None | <input type="radio"/> seizures      | <input type="radio"/> numbness/weakness         | <input type="radio"/> fainting/dizziness       | <input type="radio"/> headaches          |
| HEME:      | <input type="radio"/> None | <input type="radio"/> bruise easily | <input type="radio"/> genetic bleeding disorder | <input type="radio"/> blood clots history      | <input type="radio"/> excess bleeding    |
| ENDO:      | <input type="radio"/> None | <input type="radio"/> weight loss   | <input type="radio"/> heat/cold intolerance     | <input type="radio"/> excessive thirst         | <input type="radio"/> excess urination   |
| PSYCH:     | <input type="radio"/> None | <input type="radio"/> panic attacks | <input type="radio"/> anxiety all the time      | <input type="radio"/> inability to think       | <input type="radio"/> inability to sleep |
| OTHER:     |                            | <input type="radio"/> pregnancy     | <input type="radio"/> latex allergy             | <input type="radio"/> egg/soy allergy          | <input type="radio"/> glaucoma           |
|            |                            | <input type="radio"/> sleep apnea   | <input type="radio"/> home oxygen               | <input type="radio"/> complications of surgery |  |

**FAMILY HISTORY:** (Fill in ALL that apply and write in age at diagnosis)

	<u>Father</u>	<u>Mother</u>	<u>Sibling</u>	<u>Child</u>	<u>Grandparent</u>	<u>Other</u>	<u>Age at Diagnosis</u>
<u>Colon Cancer</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Colon Polyps</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Ulcerative Colitis</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Crohn's Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Celiac Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Liver Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Gallbladder Disease</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
<u>Pancreatic Cancer</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

List other significant diagnoses (heart disease, diabetes, etc.) or indicate if you are adopted: \_\_\_\_\_



### Consent to Receive Test Results via Patient Portal

GI Specialists of Georgia's preferred method of delivery on non-urgent test results and communication with you is via our Patient Portal.

Any patient who has internet access can obtain a summary of their medical information, is able to communicate with their physician for non-urgent or emergent matters, request appointments, request prescription refills and receive appointment reminders.

Please indicate your desire to utilize this very useful communication tool:

Yes, I wish to receive non-urgent test results and non-urgent communications via my secure patient portal access.

\_\_\_\_\_  
Current Email

No, I do not wish to use the patient portal at this time.

\_\_\_\_\_  
Patient or Legal Representative

\_\_\_\_\_  
Date

**AUTHORIZATION RELEASE**

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I have had the opportunity to review a copy of GI Specialists of Georgia, PC "Notice of Privacy Practices".

X \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

**AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION:**

I hereby give GI Specialists of Georgia, PC permission to discuss any of my Medical Information with the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is it permissible to leave Medical Information on an Answering Machine or Voicemail? YES NO

If yes, please list phone number(s) where we can leave messages: \_\_\_\_\_

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**AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:**

I hereby authorize direct payment to the doctor whose name appears for surgical or medical benefits. I understand I am financially responsible for non-covered services, co-payments and any portion of deductible not paid by the insurance company.

I hereby authorize GI Specialists of Georgia, PC to release any information required to my health insurance provider for the purpose of processing claims for services I received from GI Specialists of Georgia, PC.

X \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

I hereby authorize GI Specialists of GA, PC and all affiliated entities to obtain and share prescription medication history with my pharmacy.

X \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

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**PERMISSION TO TREAT:**

I voluntarily allow GI Specialists of Georgia, PC and all medical personnel to perform diagnostic studies, tests, x-ray examination, EKG, lab work, procedures or any other treatment or examination to me during the period of medical or surgical care, they consider pertinent.

X \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

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**CANCELLATION POLICIES:**

Our office requires 48 business hours' notice for cancellations or reschedules of office appointments or procedures. Failure to cancel or reschedule an appointment or procedure without 48 hours' notice will result in a fee of \$50.00 for procedures and \$20.00 for office appointments. Failure to show up for a scheduled procedure will result in a \$200.00 fee.

**PAYMENT:**

Co-payments and deductibles are due prior to services being performed unless other arrangements have been made with Patient Financial Services. We will file with your insurance as a courtesy; payment is the patient's responsibility. Any unpaid balance is due within 30 days of services rendered. Failure to pay could result in account being placed with an outside collection agency.

GI Specialists of Georgia (GSG) is comprised of multiple entities. In the event that one entity is overpaid for services rendered (includes the practice, facility fees, anesthesia and histology services) and there is a balance owed on another GSG entity, we reserve the right to transfer money between entities to cover open balances.

**FEE FOR COPIES OF MEDICAL RECORDS:**

In accordance with Georgia Legislative Code 31-33-3(a) there will be an administration charge for copies of all medical records.

By my signature below, I acknowledge I have read this form and I fully understand the policies and procedures.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_