GI SPECIALISTS OF GEORGIA

www.gigeorgia.com

Main Line: 678.741.5000

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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.

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

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, PC

Enclosures

GI Specialists of Georgia and Associated Entities:
DCA Diagnostics ● GI Diagnostics Endoscopy ● Towne Lake Endoscopy
Anesthesia ● Histology Services

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_____

(1) PRIMARY INSURANCE_____

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 _____

(2) SECONDARY INSURANCE_____

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_____

Emergency Contact _____Relation_____

Telephone Number _____

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.

GI Specialists of Georgia, PC 678-741-5000 www.gigeorgia.com

Revised: 01/13/2020

GASTROINTESTINAL SPECIALISTS OF GEORGIA, PC

Patient History Form

Patient Name:_____ DOB:_____ Date:_____

Primary Care Physician:_____ Referred By:_____

Race/Ethnicity (Medicare Required):_____ Height:_____ Weight:_____

MEDICATIONS: Are you on any of these medications?

O Aspirin	O Plavix/other blood thinners	O Arthritis Medications
O Ibuprofen Products	O Coumadin/Warfarin	O Insulin

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

_____

ALLERGIES: O None O Latex O Iodine O Others (please list):_____

CURRENT SYMPTOMS / ILLNESSES: Mark all that apply

O Heartburn	O Diarrhea
O Trouble swallowing	O Change in bowel habits
O Painful swallowing	O Bloody stools
O Nausea	O Weight loss/Lack of appetite
O Vomiting	O Anemia
O Abdominal Pain	O Liver problems
O Bloating, Distention, Excess Gas	O Gallbladder problems
O Constipation	O Pancreas problems

Other:_____

_____

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

	Year & Comment		*Year & Comment*
○ History of colon cancer	_____	○ Hypertension	_____
○ History of colon polyps	_____	○ Heart attack or Heart disease	_____
○ Reflux disease	_____	○ Stroke	_____
○ Barrett's esophagus	_____	○ High cholesterol	_____
○ Crohn's disease	_____	○ Lung disease	_____
○ Ulcerative Colitis	_____	○ Diabetes	_____
○ Anemia	_____	○ Cancer history	_____
○ Hepatitis	_____	○ Psychiatric disorder	_____
○ Other Liver disease	_____	○ Arthritis	_____
○ Irritable Bowel Syndrome	_____	○ Thyroid disease	_____

Please list any other pertinent medical problems:_____

_____

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

	Year & Comment		*Year & Comment*
○ Gallbladder surgery	_____	○ Coronary stent / Bypass surgery	_____
○ Stomach surgery	_____	○ Heart valve surgery	_____
○ Colon surgery	_____	○ Pacemaker / Defibrillator	_____
○ Other abdominal surgery	_____	○ Thyroid surgery	_____
○ Hemorrhoidectomy	_____	○ Hernia repair	_____

Other Surgeries:_____

_____

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

Alcohol use:	Tobacco use:	Illicit Drug use:	Have you ever had:
○ None	○ None	○ Never	○ Tattoo
○ <1 Drink/day	○ Less than ½ pack/day	○ Past Experimentation	○ Blood Transfusion
○ 1-2 Drinks/day	○ 1 pack/day	○ Former Use	
○ 3 or more drinks per day	○ More than 1 pack/day	○ Recent/Active Use	
○ Former alcohol use	○ 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:	O None	O nosebleeds	O sinus/postnasal drip	O ringing in ears	O sore throat
DERM:	O None	O skin rash	O skin itching	O skin sores	O hair loss
OPTHO:	O None	O vision change	O eye pain/redness	O double vision	O jaundice
DENTAL:	O None	O oral ulcers	O bleeding gums	O hoarseness	O bad breath
PULM:	O None	O chronic cough	O shortness of breath	O asthma/wheezing	O cough up blood
CARDIAC:	O None	O chest pain	O irregular heartbeat	O rapid heart rate	O palpitations
URINARY:	O None	O bloody urine	O frequent urination	O difficulty urinating	O painful urination
GYN:	O None	O pelvic pain	O heavy vaginal bleeding	O abnormal discharge	O irregular menses
MUSC/SKEL:	O None	O leg cramps	O pain with movement	O muscle/joint pains	O low back pain
NEURO:	O None	O seizures	O numbness/weakness	O fainting/dizziness	O headaches
HEME	O None	O bruise easily	O genetic bleeding disorder	O blood clots history	O excess bleeding
ENDO:	O None	O weight loss	O heat/cold intolerance	O excessive thirst	O excess urination
PSYCH:	O None	O panic attacks	O anxiety all the time	O inability to think	O inability to sleep
OTHER:		O pregnancy	O latex allergy	O egg/soy allergy	O glaucoma
		O sleep apnea	O home oxygen	O complications of surgery	

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

	Father	Mother	Sibling	Child	Grandparent	Other	Age at Diagnosis
Colon Cancer	O	O	O	O	O	O	_____
Colon Polyps	O	O	O	O	O	O	_____
Ulcerative Colitis	O	O	O	O	O	O	_____
Crohn's Disease	O	O	O	O	O	O	_____
Celiac Disease	O	O	O	O	O	O	_____
Liver Disease	O	O	O	O	O	O	_____
Gallbladder Disease	O	O	O	O	O	O	_____
Pancreatic Cancer	O	O	O	O	O	O	_____

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

GI SPECIALISTS OF GEORGIA

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:

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

_____
Current Email

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

_____ _____
Patient or Legal Representative Date

AUTHORIZATION RELEASE

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:_____

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

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

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:_____