



www.gigeorgia.com

Dear Patient,

Main Line: 678.741.5000

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 may result in an additional 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: _____

MEDICATIONS: Are you on any of these medications?

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

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

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

CURRENT SYMPTOMS/ILLNESSES: _____

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

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

Please list any other pertinent medical problems: _____

CONTINUED ON BACK

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

	<u>Year & Comment</u>		<u>Year & 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 ½ 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/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: _____	

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

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

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Anesthesia Signature: _____

Date: _____

Staff Signature: _____

Date: _____



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

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: _____

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

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.

CANCELLATION / NO SHOW POLICIES:

Our office requires 2 business days' notice for cancellations or reschedules of Office Appointments. Failure to cancel without 2 days' notice may result in a fee of \$20.00.

Our office requires 5 business days' notice for cancellations or reschedules of Procedures. Failure to cancel without 5 days' notice may result in a fee of \$50.00. Patients that fail to show for a procedure are subject to a \$200 fee.

Patients with a history of multiple cancelled or rescheduled procedures may result in a \$200 deposit being required prior to scheduling.

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: _____