Gastroenterology Specialist 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: _____ WK: _____
EMAIL: _____
PHARMACY NAME: _____ PHARMACY #: _____
EMPLOYER: _____
SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SSN: _____
HOME PHONE: _____ CELL: _____ WK: _____

PRIMARY INSURANCE INFORMATION
INSURANCE CO. NAME: _____ CUSTOMER SERVICE #: _____
ID #: _____ GROUP #: _____
POLICY HOLDER: _____ DOB: _____
RELATIONSHIP TO PT: _____

SECONDARY INSURANCE INFORMATION
INSURANCE CO. NAME: _____ CUSTOMER SERVICE #: _____
ID#: _____ GROUP #: _____
POLICY HOLDER: _____ DOB: _____
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 my insurance submissions. I understand I am financially responsible for all charges for office visits and procedures: 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 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 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 communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please indicate your authorized and preferred method of contact. (Check all that apply):

Preferred Method	**Alternate contact method**	**Method**	**Instructions**
○	○	Home Phone: ( )_____-_____	_leave detailed message _leave call back number only
○	○	Cell Phone: ( )_____-_____	_leave detailed message _leave call back number only
○		Work Phone: ( )_____-_____	_leave detailed message _leave call back number only
○	○	Email: **VIA Gastro Specialists <u>Secure Patient Portal.</u>** Ability to view protected health information (PHI) electronically. This requires activation.	Please send my **<u>Secure Patient Portal</u>** invitation to _____@___.__
○	○	Written Communication (appointment reminders, procedure reminders, results, etc.)	_I prefer electronic correspondence via the **<u>Secure Patient Portal</u>** _I prefer written correspondence via the Postal Mail

I hereby give my permission to discuss my healthcare with:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Record of Disclosures of Protected Health Information (office use)

Date	To Whom Disclosed	Purpose of Disclosure	By Whom Disclosed

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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?
(e.g. Aspirin, Motrin, Tagament-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).