



www.gigeorgia.com
Main Line: 678.741.5000

AUSTELL OFFICE
1700 Hospital South Drive
Suite 410
Austell, GA 30106

Phone: 770.739.9555
Fax: 770.941.2109

KENNESTONE OFFICE

711 Canton Road
Suite 300
Marietta, GA 30060

Phone: 770.429.0031
Fax: 678.819.4279

Sohail Asfandiyar, MD
Arif A. Aziz, MD
Francisco J. Cardenas, MD
Anish A. Desai, MD
David Finkelman, MD, MBA
Karim Gani, MD
Suku George, MD, MPH
Sachin Goel, MD, AGAF
Michael J. Grupka, MD
Shanil Harkins, MD
Jeffrey L. Kim, MD
Ross A. Kommor, MD
Subodh K. Lal, MD
Anuj Paul Manocha, MD
Madhuri Meka, MD
Judy Oh, MD
Priti Pandya, MD
Neal Patel, MD
Raja Sappatti Biyyani, MD
Ritesh Shah, MD
Aasim M. Sheikh, MD

Monica Agrawal, PA-C
Ayesha Azeem, PA-C
Rayllensons Itacy, PA-C
Kendra Jones, PA-C
Michelle Lovett, NP-C
Monica Redjamand, NP-C
Caroline Taylor, PA-C
Elizabeth Thai, PA-C
Isabell Wells, PA-C
Caroline Wise, PA-C

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. 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, Inc.

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 _____
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.

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

Revised: 10/20/2015

GASTROINTESTINAL SPECIALISTS OF GEORGIA, INC.
Patient Follow-Up History Form

Patient Name: _____ Age: _____ DOB: _____ Date: _____

Primary Care Physician: _____ Consult Requested By: _____

Current Symptoms/Illnesses: _____

Allergies: None Latex Iodine Others (Please List) _____

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 |

Social History:

Are you a smoker? Yes No

Alcohol Use? Yes No

REVIEW OF SYSTEMS: (Fill in ALL of the following you have experienced over the last year OR fill in "None")

- | | | | | |
|-------------------------------------|-------------------------------------|---|---|--|
| CONST: <input type="radio"/> None | <input type="radio"/> Fever | <input type="radio"/> Fatigue | | |
| ENMT: <input type="radio"/> None | <input type="radio"/> Bad breath | <input type="radio"/> Difficulty swallowing | <input type="radio"/> Jaundice | <input type="radio"/> Bleeding gums |
| | <input type="radio"/> Oral ulcers | <input type="radio"/> Sinus postnasal drip | <input type="radio"/> Nosebleeds | <input type="radio"/> Hoarseness |
| DERM: <input type="radio"/> None | <input type="radio"/> Skin rash | <input type="radio"/> Skin sores | | |
| RESP: <input type="radio"/> None | <input type="radio"/> 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 heart beat | <input type="radio"/> Rapid Heart Rate | <input type="radio"/> Palpitations |
| MUSC: <input type="radio"/> None | <input type="radio"/> Leg cramps | <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 |

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Anesthesia Signature: _____ Date: _____

Staff Signature: _____ Date: _____

AUTHORIZATION RELEASE

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

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

X _____ Date: _____
Patient Signature

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION:

I hereby give GI Specialists of Georgia, Inc. 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, Inc. 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, Inc.

X _____ Date: _____
Patient Signature

I hereby authorize GI Specialists of GA, Inc. 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, Inc. 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.

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: _____

Witness: _____



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