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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. 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 History Form

Patient Name: _____ Date of Birth: _____ 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: 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: _____

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 & Comment</u> | | <u>Year & 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 & 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 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

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: _____