Southern Gastroenterology Associates, L.L.C. *Phone (678) 985-2000*

Patient Information Form

Please complete these forms and bring them with your insurance card and identification to your appointment. Thank you

Please fill out each section completely.

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: Male / Female **Marital Status:** S M W D **Race:** _____

Mailing address: _____ **City/State** _____ **Zip** _____

County of Residence: _____ **E-mail:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Social Security No. _____
Your ss# is required if you wish for SGA to file to your insurance. Thank you for your cooperation.

Emergency Contact: _____
Phone: _____

Primary Insurance Policy Information

Insurance Company: _____

Name of Policyholder: _____ **Date of Birth:** _____
The policyholder is the person who carries the insurance policy.

Member ID: _____ **Group or Group #:** _____

Relation to patient:
☐ Patient ☐ Spouse ☐ Child ☐ Other _____

SS of policyholder: _____

Secondary Insurance Policy Information

Do you have a Third Insurance? **YES NO**

Insurance Company: _____

Name of Policyholder: _____ **Date of Birth:** _____
The policyholder is the person who carries the insurance policy.

Member ID: _____ **Group or Group #:** _____

Relation to patient:
☐ Patient ☐ Spouse ☐ Child ☐ Other _____

SS of policyholder: _____

Primary Care Physician: _____ **Phone:** _____

Whom may we thank for your referral? _____

Please present your drivers license and insurance card(s) to the receptionist. If you do not have a copy of your insurance card and you are not able to obtain one, you will be considered a Self Pay patient. Payment is due at the time of service, or you may reschedule your appointment.

It is each patient's responsibility to obtain a referral if their insurance requires one. If you have not provided our office with a referral at check-in, you will be considered a Self Pay patient. Payment is due at time of service, or you may reschedule your appointment. COPAYMENTS ARE DUE AT CHECK-IN.

I hereby authorize the release of any medical information, including HIV/AIDS or other confidential information necessary to process insurance claims or any medical information that is required for healthcare utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to SGA. I hereby sign and authorize payment to SGA for charges incurred by me or on my behalf. I hereby accept responsibility for all medical fees and charges incurred by me or on my behalf, and I accept responsibility for payment. This agreement shall remain in effect until revoked by me in writing. A photocopy of this agreement shall be considered as effective and valid as the original. I understand that I have a right to receive a copy upon request.

We require your permission to release information contained in your chart to anyone, including family members.
For instance: Appt information and lab results. **Do we have permission to release this information?** ☐**YES** ☐**NO**
If yes, to whom specifically may information be released?: _____

Patient/Guarantor Signature: _____ **Date:** _____

Welcome Back! to Southern Gastroenterology Associates

Patient Name: _____ Date of Birth: _____ Today's Date: _____

To assist us in your healthcare needs, please update us on the following information:

Physician Notes:

1. The reason for today's visit:
   - ☐ Routine Follow-Up
   - ☐ New Problem: _____

2. Any new medical problems since your last visit?
   i.e., Surgery, E.R., or Hospitalization?
   - ☐ None ☐ Emergency Room? Where? When? _____
   - ☐ Yes describe problem: _____

3. Have you had any recent blood tests or x-rays done? If yes, where and when?

4. Have you seen your PCP, or any physician regarding today's problem? Who?

5. Have there been any changes in your medications?
   - ☐ See Attached List of prescription medicines, over-the-counter medicines and supplements/vitamins.
   - ☐ I am taking the following prescription medicines, over-the-counter medicine and supplements/vitamins.

Medicine	Dose	How Often	Medicine	Dose	How Often

6. Please list all allergies to medications:

   Medicine Reaction: