

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. Emergency Contact:
Your ss# is required if you wish for SGA to file to your insurance. Thank you for your cooperation. 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: SS of policyholder:
Patient Spouse Child Other

Secondary Insurance Policy Information

Insurance Company: Do you have a Third Insurance? YES NO
Name of Policyholder: Date of Birth:
The policyholder is the person who carries the insurance policy.
Member ID: Group or Group #:
Relation to patient: SS of policyholder:
Patient Spouse Child Other

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:

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?

Physician Notes:

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:
