

**PATIENT REGISTRATION**

Dr. D. Brad Lord DATE: \_\_\_\_\_ Patient Account Number: \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT'S NAME: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL / PAGER: \_\_\_\_\_ SOC SEC #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SOC SEC #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

POLICY HOLDER: \_\_\_\_\_ PATIENT I.D. #: \_\_\_\_\_

POLICY HOLDER D.O.B.: \_\_\_\_\_ RELATIONSHIP TO PT: \_\_\_\_\_

INSURANCE CO. NAME: \_\_\_\_\_ CUSTOMER SERVICE #: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

POLICY HOLDER: \_\_\_\_\_ PATIENT I.D. #: \_\_\_\_\_

POLICY HOLDER D.O.B.: \_\_\_\_\_ RELATIONSHIP TO PT: \_\_\_\_\_

INSURANCE CO. NAME: \_\_\_\_\_ CUSTOMER SERVICE #: \_\_\_\_\_

**\*\*PRIMARY CARE PHYSICIAN \*\***

**\*\*REFERRING PHYSICIAN \*\***

NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_ NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION-(Someone not living with you)**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ CONTACT #: \_\_\_\_\_

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: my insurance 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 at Gwinnett Medical Center, that a facility fee will be charged and that any deductibles, copays, etc which may apply are my responsibility. Any amount not paid by 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 any collection fees, attorney fees, court costs, etc. should account be turned over to collections.

\_\_\_\_\_  
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

**\*\* MUST BE FILLED OUT TO PROCESS CLAIM\*\***

**Gastroenterology Specialists Of Gwinnett, P.C.**

Zack Z. Martin, M.D.

D. Brad Lord, M.D.

W. Gordon Tanner, Jr. M.D.

Jae W. Nam, M.D.

**Personal History**

Patient Name: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**History of Illness:**

Please describe the problem(s) you are having: \_\_\_\_\_

\_\_\_\_\_

Please list all past surgeries, hospitalizations, significant medical illnesses, and cancers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications - including herbal and vitamins:

Name of Med

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle any of these medicines that you have tried:

Zantac ; Tagamet ; Pepcid ; Axid ; Prevacid ; AcipHex ; Prilosec ; Protonix

Drug Allergies:

Name of Medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Give details regarding current and past use of (estimate daily or weekly usage):

Alcohol: Amount \_\_\_\_\_

Tobacco: Amount \_\_\_\_\_

**Family History (Blood Relative):**

Is there a history of colon cancer/polyps? Y N Who: \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Review of Systems and Symptoms:**

Check each box that applies, and explain to the right to accurately describe your symptoms.

Yes No

**Constitutional**

- Weight loss
- Fever
- Fatigue
- Weakness
- Other \_\_\_\_\_

**Ear, Nose, Mouth, Throat**

- Hearing loss
- Ear Pain/Ringing
- Mouth ulcers or Sores
- Poor Dentition
- Nose Bleeds
- Difficulty in Swallowing
- Other \_\_\_\_\_

**Eyes**

- Glaucoma
- Vision Loss
- Other \_\_\_\_\_

**Lungs**

- Shortness of Breath
- Asthma/Wheezing/Cough
- Other \_\_\_\_\_

**Genitourinary**

- Are you pregnant?  
Date of last period \_\_\_\_\_
- Recent/Frequent Urinary Tract Infection
- Blood in Urine
- Burning with Urination
- History of Kidney Stones
- Other \_\_\_\_\_

**Musculoskeletal**

- Lupus, Scleroderma, Related Disease
- Joint Pain/Arthritis
- Back Pain
- Other \_\_\_\_\_

**Skin**

- Dermatitis or Rash
- Itching
- Psoriasis
- Other \_\_\_\_\_

**Allergic/Immunologic**

- HIV/AIDS

Yes No

**Abdominal**

- Difficulty Swallowing
- Heartburn/Esophageal Reflux
- Nausea/Vomiting
- Hiatal Hernia
- Indigestion
- Bloating/Belching/Gaseousness
- Abdominal Pain
- Peptic Ulcer
- Gallstones/Gallbladder Disease
- Hepatitis or Liver Disease
- Crohn's Disease/Ulcerative Colitis
- Irritable Bowel Syndrome
- Gastrointestinal Bleeding
- Hemorrhoids
- Constipation
- Diarrhea/Loose Stool
- Change of Bowel Habit
- Other \_\_\_\_\_

**Heart**

- Chest pain
- Pacemaker
- History of Heart Attack
- Mitral Valve Prolapse or Murmur
- Artificial Heart Valve
- Hypertension
- Other \_\_\_\_\_

**Neurological**

- Seizure Disorder
- Headache
- Stroke
- Other \_\_\_\_\_

**Psychiatric**

- Depression or Anxiety
- Past Evaluation or Treatment
- Other \_\_\_\_\_

**Endocrine**

- Thyroid Disease
- Diabetes
- Other \_\_\_\_\_

**Hematologic/Lymphatic**

- Enlarged Nodes or Swollen Glands
- Anemia
- Bleeding Problems
- Other \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

