

PATIENT REGISTRATION

Dr. Jae W. Nam 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: _____

