Gwinnett Surgical Associates

Your Name: _____**Today's Date**_____

Will you need special accommodations for a medical service of any kind at the office visit Yes__ No__

If yes please specify:_____

Preferred Name: _____ **Primary Language**: _____

Date of Birth: _____ **SSN**: _____

Preferred Pharmacy, Address, Phone #, & City: _____

Race: ❒ American Ind./Alaska Native ❒ Asian ❒ Black/African American ❒ White ❒ Other

❒ Nat Hawaiian/Pacific Islander ❒ Declined **Marital Status:** S M D W

Ethnicity: (*MUST COMPLETE*) ❒ Hispanic or Latino ❒ Non Hispanic or Latino ❒ Declined

Address: _____ **Apt#** _____

City: _____ **State**: _____ **Zip Code**: _____

Home # _____ **Work #** _____ **Cell #** _____

Email: _____ **Employer:** _____

Preferred Communication for Appointment Reminders: ❒ Email ❒ Phone ❒ Text ❒ Other_____

Emergency Contact: _____ **Relationship:** _____ **Phone #** _____

Is your Insurance through (please check all that apply): ❒ My employer ❒ Private ❒ Spouse ❒ Parent

Policy Holder Employer: _____ **ID#** _____

Insurance Co. Name: _____ **Group Name/#** _____

Insurance Company Address: _____

Policy Holders Name: _____

Policy Holders DOB (*MUST HAVE*): _____ **Policy Holders SSN#** _____

Secondary Insurance Name: _____ **ID#** _____ **Group Name/ #**_____

Insurance Company Address: _____

Policy Holders Name: _____

Policy Holders DOB (*MUST HAVE*): _____ **Policy Holders SSN#** _____

Is this workers comp ❒ Yes ❒ No **If yes, Contact Name:** _____ **Phone** _____

Date and Nature of Injury: _____

It is the policy of this office to pay for services in full when rendered. We will file your claim and you will be expected to pay only what the insurance does not pay. You must have your current insurance card at time of service or you will be expected to pay in full. Return check fee is $30. A no show fee of $25 for office visit will be charged. A $100 for procedures in office, hospital, or surgery center will be billed if notification of cancellation of appointment is not received at least 24 hours prior to scheduled procedure. Insurance is not a guarantee of payment. It is your responsibility to confirm your benefits. In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred. If this account is placed with a collection agency, the undersigned parties agree to pay all fees for cost of collections.
I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of this claim.
PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____
HIPPA PRIVACY RULE: Please list the parties that you authorize Gwinnett Surgical Associates to disclose you protected health information (PHI). **MUST BE FILLED OUT BY PATIENT only**
Name:_____ Relationship:_____
Name:_____ Relationship:_____
I HAVE RECEIVED/READ A COPY OF GWINNETT SURGICAL ASSOCIATES NOTICE OF PRIVACY PRACTICES.
*Patients Initials*_____

Referring Physician_____ Phone #_____
Reason for Visit Today:_____
Drug Allergies:_____
Medications and Dosage you are taking:_____
_____
_____

Do You Smoke❒ Yes ❒ No How Long:_____ How many per day:_____ Alcohol Intake: ❒yes ❒no
Respiratory: Doctor's Name:_____
Please check all that apply: ❒ Sleep Apnea ❒ COPD ❒ Asthma ❒ Bronchitis ❒ Pulmonary Embolus
❒ Lung Cancer ❒ Tuberculosis ❒ Pneumonia ❒ Shortness of Breath/Cough ❒ Cough up Blood

Cardiovascular: Doctor's Name: _____
❒ Heart attack: When _____ ❒ Coronary Artery Disease ❒ Heart Failure / CHF ❒ Abnormal EKG
❒ Arrhythmia ❒ Pacemaker/defibrillator ❒ Angioplasty/Stent ❒ Heart Valve ❒ Angina/chest pain
❒ Stroke ❒ Hypertension ❒ High Cholesterol ❒ Blood Clot/DVT ❒ Leg Swelling ❒ Pain with walking
❒ Non- healing wounds ❒ Varicose Veins

GI: Doctor's Name: _____
❒ GERD ❒ Weight Loss ❒ Blood in Stool ❒ Change in Bowel Habits ❒ Constipation
Endocrine: Doctor's Name: _____
❒ Diabetes: Diet / Pill / Insulin / Pump ❒ Thyroid Disease: Hypo / Hyper ❒ Abnormal Calcium Level

PRIOR SURGERY, ILLNESS, OR INJURY AND ANY COMPLICATIONS:_____
_____