Gwinnett Surgical Associates
Patient Registration

Your Name: _____ Date: _____
Will you need special accommodations for a medical service of any kind at the office visit? YES____ NO____
If yes, please specify: _____

Date of Birth: _____ SSN: _____ Primary Language: _____

Address: _____ APT# _____
City: _____ State: _____ Zip Code: _____

Home # _____ Work # _____ Cell #_____

Email: _____ Employer:_____

Emergency Contact: _____ Relationship: _____ Phone # _____

Marital Status: S M D W

Race(Circle One) American Ind./Alaska Native Asian Black/African American White
Nat Hawaiian/Pacific Islander Declined

Ethnicity (Circle One) Hispanic/Latino Non Hispanic/Latino Declined

INSURANCE INFORMATION

Is your Insurance through (Circle all that apply) My Employer Private Spouse Parent

*Primary Insurance Co Name: _____ ID # _____
Policy Holder Employer: _____ Group Name/# _____
Insurance Co Address: _____
Policy Holder Name: _____ Policy Holder DOB: _____ Policy Holder SSN: _____

*Secondary Insurance Co Name:_____ ID# _____
Group Name/# _____ Policy Holders Name: _____
Insurance Company Address: _____
Policy Holders DOB: _____ Policy Holder SSN: _____

Is this Workers Comp? (Circle One) YES NO If yes, Contact Name: _____ Phone:_____
Date and Nature of Injury: _____

TODAY'S VISIT

Referring Physician: _____ Phone #: _____
Reason for Today's Visit: _____

***Preferred Pharmacy Name**: _____

***Drug Allergies**:_____

***Medications and Dosage being taken**:

_____
_____
_____
_____

Do You Smoke?(Circle One) YES NO If yes, how long?_____ How many per day? _____
Alcohol Intake? (Circle One) YES NO If yes, how often? _____

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MEDICAL HISTORY

Respiratory Doctor's Name: _____
Please circle 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: _____
Please circle all that apply: Heart Attack (when?_____) Coronary Artery Disease Heart Failure/CHF
Abnormal EKG Arrhythmia Pacemaker/Defibrillator Angioplasty/Stent Heart Valve
Angina/Chest Pain Stoke Hypertension High Cholesterol Blood Clot/DVT
Leg Swelling Pain with Walking Non-Healing Wounds Varicose Veins

GI Doctor's Name: _____
Please circle all that apply: GERD Weight Loss Blood in Stool Constipation Change in Bowel Habits

Endocrine Doctor's Name: _____
Please circle all that apply: Diabetes Diet/Pill/Insulin/Pump Thyroid Disease Hypo/Hyper Abnormal Calcium Level

Prior Surgery, Illness, or Injury and Complications: _____
_____
_____

GSA Policy/HIPPA Information

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 the time of service or you will be expected to pay in full. Return check fees are $30.00. A no show fee of $25.00 for office visit will be charged. A $100.00 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 your protected health information (PHI). MUST BE FILLED OUT BY PATIENT ONLY.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Initials: _____