

New Patient Information Form

You may print this and bring it with you for your appointment, or fax it to 678-985-1999. Appt Date: _____

Please fill out each section completely.

Patient Name: _____ Date of Birth: _____ Age: _____

CIRCLE ONE: Gender: Male / Female CIRCLE ONE: Marital Status: S W M D Race: _____

Mailing address: _____ City/State _____ Zip _____

County of Residence: _____

Daytime Phone: _____ Evening: _____ Alternate: _____

Social Security No. _____

Your ss# is required if you wish for SGA to file to insurance. Thank you for your cooperation.

Emergency Contact: _____

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:

patient spouse child other _____

SS of policyholder: _____

Secondary 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:

patient spouse child other _____

SS of policyholder: _____

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 each patient's responsibility to obtain a referral if your 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 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.

Do we have permission to release information contained in your chart to any family member over the phone?

For instance: Appt information and lab results? YES NO

If yes, to whom specifically may the information be released?: _____

Signature: _____ Date: _____



FAMILY HISTORY

Spouse	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	Present Health or Cause of Death	Mother	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	Present Health or Cause of Death	Father	Living <input type="checkbox"/> Deceased <input type="checkbox"/>	Present Health or Cause of Death
		# Living	Ages & Health Status		# Deceased	Ages & Cause of Death		
Children								
Brothers/Sisters								

Please check the illnesses which have occurred in any of your **blood relatives**:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease, Crohn's Disease or Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency

SOCIAL HABITS

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have dentures?
<input type="checkbox"/>	<input type="checkbox"/>	Are you on a special diet? What type of diet: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco?
<input type="checkbox"/>	<input type="checkbox"/>	How many packs per day? _____ How many years? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you smoked in the past?
		How many packs per day? _____ How many years? _____
		When did you quit? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?
		Number of drinks per week: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a problem with alcohol in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever used IV drugs in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a drug problem now or had a problem in the past?
		What is your daily intake of:
		Coffee/cups per day: _____
		Tea/cups per day: _____
		Sodas/cups per day: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any major or significant loss/change in your life recently?
		If yes, please explain: _____

What is your occupation? _____

What does this require you to do? _____

Patient Name: _____ Date: _____



Marital Status: S M W D Age: _____ Date of Birth: _____ Sex: _____

PRESENT ILLNESS

Please describe the reason for today's visit: _____

How long have you had this problem?
Weeks: _____ Months: _____ Years: _____

Yes No Have you been treated for this problem before?

Yes No Have you had any tests up to this point?
If yes, please list: Date Results (if known)

Bloodwork: _____

X-Ray: _____

Yes No Any previous endoscopy procedures?
If yes, please list: Date Results (if known)

CURRENT MEDICATIONS

List all present medications including over the counter drugs, vitamins, etc.:

Medication	Dose	How Often	Medication	Dose	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Yes No Do you have any allergies to medication?
If yes, please list medication and type of reaction: _____

PAST MEDICAL HISTORY

Please list any operations and/or hospitalizations

Year	Type of Surgery/Reason for Hospitalization	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ Date: _____



HEALTH REVIEW

PLEASE INDICATE MOST RECENT SYMPTOMS AND PRIOR MEDICAL PROBLEMS

	YES	NO		YES	NO
Lack of Energy	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Recent Appetite Change	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever/Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Black or Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood from Rectum	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Menstrual Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____		
Depression	<input type="checkbox"/>	<input type="checkbox"/>			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/> *	<input type="checkbox"/>	*Type of Cancer: _____		

FOR OFFICE USE

DATE	REVIEWED BY	INITIALED

Patient Name: _____

Date: _____