Steven Sangha, M.D.
Atlanta Gastroenterology Specialists PC

Patient Number _____

Patient Registration

Date: _____

Patient Information

Social Security # _____

First Name_____Middle Initial___

Last Name _____

Date of Birth__/__/__ Gender: Male Female

Driver's License #_____State _____

☐ Employed FT Employed PT Student FT
☐ Other _____

Employer_____

Employer Address _____

Suite_____City_____

State_____Zip_____

Employer Phone _____

Referring Physician _____

Primary Address:
_____

City_____State_____Zip_____

Email Address:
_____

Phone Numbers – Important – Please fill out.

Home Phone_____

Work Phone _____

Cell Phone _____

How did you hear of us?

Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial Medicaid Medicare Worker's Compensation Other _____

Insurance Company:_____Policy #_____Group #_____

Insured / Card Holder's Name_____Relationship to Patient _____

Insured D.O.B. __/__/__ SSN#_____Phone_____

Employer City / State_____Phone_____

Secondary Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial Medicaid Medicare Worker's Compensation Other _____

Insurance Company:_____Policy #_____ Group # _____

Insured / Card Holder's Name_____ Relationship to Patient _____

Insured D.O.B.___/___/___SSN#_____Phone _____

Employer City / State_____Phone _____

Pharmacy Information

Pharmacy Name_____ Phone _____

Address_____ City_____State_____Zip _____

Emergency Contact

Full Name (First, Middle,Last _____Phone_____

Relationship to Patient_____Gender Male Female

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
Signature (Patient or Parent, if minor) Date

_____
Signature (Patient or Parent, if minor) Date

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www.atlgastrospec.com

Release of Information

Section I

- I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.
- I hereby assign and authorize payment to Atlanta Gastroenterology Specialists PC of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.
- I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Atlanta Gastroenterology Specialists PC by any insurance policy, self-insurance program or other benefit plan.
- This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Section II

Check one: *I [☐ **DO]** or [☐**DO NOT]** authorize you to contact or leave messages at my place of work.*

Check one: *I [☐ **DO]** or [☐**DO NOT]** authorize you to contact me at my e-mail address.*

E-mail address if authorized _____

*I **DO** authorize you to share information with:*

Name & Relationship: _____

I hereby authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. [The laboratory results are NEVER left on the answering machine. You have to call the office to get them.]

Patient Name: _____

Patient Signature (Parent if patient is a minor): _____

Relationship to patient if not patient: _____

Date: _____

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678-957-0057

Authorization to Release Medical Records

Patient Name:

Date of Birth SSN#

Send records to: **Atlanta Gastroenterology Specialists**
Attention: Patient Records
4395 Johns Creek Parkway, Suite 130
Suwanee, Georgia 30024
Fax: 678-957-0047

Specific Description of Information – indicate treatment dates for each requested item

X Office Notes From _____ To_____ ☐ xxRadiology Reports From _____ To_____

X Lab Reports From _____ To _____ ☐ xxPathology Reports From _____ To _____

☒ Proc Reports From _____ To _____ ☐ **xx Entire Record – all documents listed above without exception**

The information described above will be used or disclosed for the following purpose(s):
☒Continuity of care ☐Transfer of care

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form , unless that treatment is for a fitness-for-duty evaluation or a records-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations then such information may be re-disclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to: Atlanta Gastroenterology Specialists PC 4395 Johns Creek Pkwy Ste 130 Suwanee GA 30024 Any revocation will not affect disclosures made prior to Atlanta Gastro Specialists PC receipt of knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form. I certify that I have received a copy of this authorization.

Signature of patient or patient's rep | Printed name of patient's representative | Relationship to patient

Date: _____

Expiration date of authorization:_____(unless otherwise noted, this authorization will expire 12 months from the date of signature)

Atlanta Gastroenterology Specialists, P.C.
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Digestive Care Patient Questionnaire

Patient Name:_____ **Date:**_____

It is very important that your physician has current and accurate information in order for him to provide you with the best medical care available. Please take your time in answering the following questions.

Requesting Physician:_____

Primary Care Physician:_____

My Chief Complaint is:_____

I was referred here for:_____

Present Medications/ Dose Please List ALL	**ALLERGIES**

Have you been on Steroids/ 6MP or Azathiprine ? If so how long and how much

Have you ever been on Remicade,Humira or Cimzia? If so which med ,when and how long did you take the medication_____

_____

Indicate if you have had *any* of the following GI Procedures and approximate date (months/years ago) --and findings, if known.

Exam	Exam Date	Findings:
☐ **Colonoscopy**		
☐ EGD (Endoscopy)		
☐ Capsule Endoscopy		
☐ ERCP		
☐ CT SCAN		
☐ Ultrasound		
☐ UGI Series		
☐ Small Bowel Series		
☐ Barium Enema		
☐ MRI		
☐ **Other:**		
☐ Other:		

Indicate if ***you*** **presently have** or **have been treated** for *any* of the following gastrointestinal conditions

☐ Barrett's Esophagus	☐ Gastritis
☐ Upper GI Bleeding	☐ Gallbladder Disease
☐ Rectal Bleeding	☐ Hepatitis Type
☐ Colon Polyps	☐ Hiatal Hernia
☐ **Colon Cancer When?**	☐ Irritable Bowel Syndrome
☐ Constipation	☐ Liver Disease
☐ **Crohn's Disease Location_____**	☐ Ulcer Disease (Gastric or Peptic)
☐ Diverticulosis	☐ **Ulcerative Colitis**
☐ Esophageal Reflux	**OTHER**

Indicate if you **presently have** or **have been treated** for *any* of the following general medical conditions **Please be Specific**

☐ Anemia	☐ Diabetes Mellitus
☐ Asthma	☐ HIV
☐ Atrial Fibrillation	☐ Hyperlipidemia
☐ **Cancer TYPE/Location**	☐ Hypertension
	☐ Kidney Disease
☐ COPD	☐ Neurologic Disorders
☐ Congestive Heart Failure	☐ Thyroid Disorders
☐ Coronary Artery Disease/Heart Attack	☐ Valvular Heart Disease

ALL OTHER Med Conditions

_____

_____

_____

Indicate if you **have had any** of the following surgeries and approximate date

Surgery	Date	Surgery	Date
☐ Appendectomy		☐ Coronary Artery Bypass Graft	
☐ Biliary Surgery		☐ Heart Valve Replacement	
☐ Fistula Surgery		☐ Hernia Repair	
☐ Colon Polyps		☐ Inguinal Hernia Repair	
☐ Colon Resection Partial		☐ Pacemaker Placement	
☐ Hemorrhoidectomy		☐ Ovaries removed	
☐ Gastric Surgery		☐ Tonsils-Adenoids	
☐ Small Bowel Resection		☐ TURP	
☐ Ulcer Surgery		☐ Prostate Radiation seeds	
☐ Gastric Bypass		☐ Gastric Lap Band	
☐ Gall Bladder Removal		☐ Other:	

Indicate if anyone in your **immediate family** has had any of the following diseases

Diagnosis	Relationship	Diagnosis	Relationship
Breast Cancer		Diabetes	
Colon Cancer		Early Death	
Colon Polyps		Heart Disease	
Ovarian Cancer		Hepatitis	
Prostate Cancer		Hypertension	
Cancer - Other		Liver Disease	
Depression		Thyroid Disorder	

Social Information & History

Occupation:	_____			
Current Status:	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Alcohol Use:	☐ Yes ☐No	If yes, frequency: _____	How much: _____	
Caffeine Use	☐ Yes ☐No	If yes, frequency: _____	How much: _____	
Smoking	☐ Yes ☐No	_ packs / day -----cigarettes / day	When did you quit?	
Recreational Drug Use	☐ Yes ☐No			
Influenza Vacc	When_____	**PNEUMOVAX Vaccine**	When_____	
Exercise Habits	How often?	_____	What type?	_____

Indicate if you presently have or are being treated for any of the following symptoms:

General
Chills _____
Fever _____
Night Sweats _____
Feeling tired or poorly (malaise) _____
Other (weight gain / loss)

Head Symptoms
Headache _____
Facial pain _____
Sinus pain _____
Other head symptoms _____

Eye Symptoms _____
Worsening vision _____
Blurred vision _____
Vision distortion _____
Other eye symptoms

Otolaryngeal Symptoms
Earache _____
Nosebleeds (epistaxis) _____
Nasal discharge _____
Mouth sores _____
Bleeding gums _____
Hoarseness _____
Throat pain

Neck Symptoms
Neck pain _____
Neck stiffness _____
Lump or swelling in neck area _____
Other neck symptoms

Cardiovascular symptoms
Chest pain or discomfort _____
Fast heart rate _____
Palpitations _____
Other cardiovascular symptoms _____
_____

Pulmonary Symptoms
Shortness of breath _____
Cough _____
Coughing up blood (hemoptysis) _____
Wheezing _____
Other Pulmonary symptoms _____

Genitourinary Symptoms
Dysuria-burning, difficulty urinating _____
Increased urinary frequency _____
Hematuria (blood in urine) _____
Other: _____

Female (GYN)
Vaginal bleeding _____
Vaginal discharge _____
Vaginal pain during intercourse _____
_____

Skin Symptoms _____
Pruritus (itching) _____
Skin lesions _____
Rashes _____
Other skin symptoms:

Stool Description if abnormal
Change in stool color _____
Change in stool character _____
Size of the stool has changed _____
Consistence of the stool has changed _____
Foul smelling _____
Diarrhea _____
Other GI symptoms

Musculoskeletal Symptoms
Joint pain, localized _____
Joint stiffness, localized _____
Muscle aches _____
Low back pain

Neurological Symptoms
Dizziness _____
Vertigo _____
Fainting (syncope) _____
Motor disturbances _____
Sensory disturbances _____

Psychological Symptoms
Sleep disturbances _____
Anxiety _____
Depression _____
Other psychological symptoms: _____

None of the above apply to me _____ Signature_____ DATE_____