

**Atlanta South Gastroenterology, PC / Atlanta South Endoscopy Center, LLC Patient Registration Form**

<b>PATIENT INFORMATION – PLEASE PRINT CLEARLY</b>										
Last Name			First Name			MI	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss			
Date of Birth	Age	Sex	Social Security #			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Home Address				Apt. #	City			State	Zip	
Home Phone	Work Phone		Cell Phone		Employer			Employer Phone		
Name of Responsible Party			Address				Phone			
Name of Emergency Contact		Relationship		Address			Home Phone		Cell Phone	
Pharmacy Name		Pharmacy Location			Pharmacy Phone		Pharmacy FAX			
Primary Care Physician			Primary Physician Address				Primary Physician Phone			
Referring Physician			Referring Physician Address				Referring Physician Phone			
Name of Primary Insurance					Name of Secondary Insurance					

**AUTHORIZATIONS & ACKNOWLEDGEMENTS: YOUR INITIALS INDICATE CONSENT**

<b>Benefits</b>	_____ INITIALS	I request that payment of authorized benefits be made to <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C.</b> and/or <b>ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> . I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.  I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.  I hereby assign and authorize payment to <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C.</b> and/or <b>ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of 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. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C./ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> 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.	
	<b>Privacy</b>	_____ INITIALS	I acknowledge that I have received a copy of the "Notice of Privacy Practices."
		_____ INITIALS	I <input type="checkbox"/> <b>DO</b> <input type="checkbox"/> <b>DO NOT</b> authorize <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C.</b> and/or <b>ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> to discuss my appointments, medical evaluation, treatment and results to relatives or other persons as indicated: Authorized person(s): _____
<b>Contact Rules</b>	_____ INITIALS	I <input type="checkbox"/> <b>DO</b> <input type="checkbox"/> <b>DO NOT</b> authorize <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C.</b> and/or <b>ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. I realize I must call the office to obtain laboratory results.	
	_____ INITIALS	I <input type="checkbox"/> <b>DO</b> <input type="checkbox"/> <b>DO NOT</b> authorize <b>ATLANTA SOUTH GASTROENTEROLOGY, P.C.</b> and/or <b>ATLANTA SOUTH ENDOSCOPY CENTER, LLC</b> to contact me at work or leave messages for me at work.	
<b>Living Will</b>	_____ INITIALS	I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I also acknowledge that: I <input type="checkbox"/> <b>DO</b> <input type="checkbox"/> <b>DO NOT</b> have Advance Directives (either a Living Will or a Durable Power of Attorney for Health Care.) If I do not have such Advance Directives at this time, but establish them at a later date, I will provide the Office/Center with a copy.	
<b>Transfer</b>	_____ INITIALS	I understand that in case of an emergency at any of our offices, I will be transferred to the nearest hospital emergency room.	

\_\_\_\_\_  
Patient/Legal Guardian/Authorized Person (Signature)

\_\_\_\_\_  
Relationship if other than Patient

\_\_\_\_\_  
Date Signed