Atlanta Surgery Associates

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____

Primary Care Physician________________________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Email Address	Employer/Occupation	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Online ❑ Other ____________________

Other Family Members Seen Here ____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Atlanta Surgery Associates or insurance company to release any information required to process my claims.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

PLEASE BE AS THOROUGH AS POSSIBLE. EVERYTHING THAT IS ASKED IS FOR MEDICAL PURPOSES.

PATIENT MEDICAL HISTORY

Patient Name______________________________ Date__________________

Age_________ DOB____________ Referring Physician____________________

Reason for Visit____

Symptoms

General	**Ear, Nose, Throat**	**Cardiovascular**	**Gastrointestinal**	**Genitourinary**
☐ Chills	☐ Loss of Hearing	☐ Chest pain	☐ Bloating	☐ Infections
☐ Fever	☐ Blurred Vision	☐ Palpitations	☐ Bowel Changes	☐ Discharge
☐ Lack of Appetite	☐Sinus Problems	☐ Poor Circulation	☐ Constipation	☐ Painful sex
☐ Weight Loss	☐ Swallowing Prob	☐ Swollen ankles	☐ Diarrhea	☐ Erectile problem
☐ Weight Gain	☐ Hoarseness		☐ Nausea	☐ Bloody urine
☐ Fatigue		**Respiratory**	☐ Vomiting	
☐ Unable to Sleep	**Muscle/Joint**	☐ Wheezing	☐ Indigestion	**Psychiatric**
☐ Weakness	☐ Pain ________	☐ Cough	☐ Abdominal Pain	☐Hallucinations
☐ Sweats	☐ Numbness_____	☐ Short of breath	☐ Rectal Bleeding	☐Paranoia
☐ Dizziness	☐ Swelling ______	☐ Bloody Sputum	☐ Rectal Pain	☐Confusion
☐ Headache	☐ Weakness _____	☐Pain w/Breathing	☐ Bloody Stools	
			☐ Black Stools	**Skin**
Hormonal	**Neurological**	**Other**	☐	☐ Rashes
☐ Heat Intolerance	☐ Fainting	☐	☐	☐ Itching
☐ Cold Intolerance	☐ Memory Loss	☐	☐	☐ Bruise easily
☐ Excess Thirst	☐ Paralysis	☐	☐	☐ Change in moles
☐ Excess Sweating	☐ Tremors	☐	☐	☐ Sores

Past Medical History

☐ Unremarkable	☐ Stroke	☐ Multiple Sclerosis	☐ HIV
☐ Asthma	☐ Migraine	☐ Lupus	☐ AIDS
☐ COPD	☐ Arthritis	☐ Depression	☐ Cancer _________
☐ Hypertension	☐ Thyroid Disease	☐ Seizure Disorder	☐ Currently pregnant
☐ Diabetes	☐ Hepatitis	☐ Anxiety Disorder	☐ Bleeding Disorder
☐ High Cholesterol	☐ Liver Disease	☐Crohn's/Ulc.Colitis	☐ On Plavix
☐ Kidney Disease	☐ Breast Cancer	☐ Gout	☐ On Coumadin
☐ Heart Disease	☐ Colon Cancer	☐Pacemaker	☐ On dialysis

Other:____

Medications:

Allergies: ______________________________ ***Pharmacy** ______________________________

Social History

Marital Status	□Single	□Married	□Divorced	□Partnered	
Children	□None□Number ____________				
Tobacco Use	□Never	□Current smoker (__packs per day)	□Former Smoker (year quit____)		
Alcohol Use	□Never	□Occasional	□Daily	Type______________	Amount____________
Drug Use	□Never	□Occasional	□Daily	Type______________	Amount____________
Exercise	□Never	□Occasional	□Daily	Type______________	Amount____________

Family History

Relation	Age	Health	Cause of Death	Health Problems
Father				
Mother				
Brother(s)				
Sister (s)				

Past Surgery History

□ Unremarkable	□ Colon Resection	□ Heart Bypass	□ Brain Surgery
□ Appendix Removed	□ Removal of Spleen	□ Valve Replacement	□ Prostate Surgery
□ Gallbadder Removed	□ Removal of Kidney	□ Pacemaker	□ Vascular Surgery
□ Hysterectomy	□ C Section	□ Tubal Ligation	□ Vasectomy
□ Mastectomy Right__ Left__	□ Lumpectomy Right__ Left__	□ Axillary Nodes Right__ Left__	□ Breast Biopsy Right__ Left__
□ Thyroidectomy	□ Groin Hernia Repair	□ Hip Replacement	□Hemorrhoidectomy
□ Gastric Bypass	□ Ventral Hernia Repair	□ Knee Replacement	□ Tonsillectomy
□ Bowel Resection	□Hiatal Hernia Repair	□ Spine Surgery	□ Transplant_________

Other: ____

PLEASE BE AS THOROUGH AS POSSIBLE. EVERYTHING THAT IS ASKED IS FOR MEDICAL PURPOSES.

Thank you.

Atlanta Surgery Associates

Statement of Patient Financial Responsibility

Patient Name: ____ **DOB:** ____________________

Atlanta Surgery Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Atlanta Surgery Associates, for providing medical services to me, the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Atlanta Surgery Associates, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ______________________

Guarantor Signature ____ Date ______________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a Co-Pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ___________________________________ Date ______________________

Consent for Treatment and Authorization to Release Information

I hereby authorize Atlanta Surgery Associates, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Atlanta Surgery Associates, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature ___________________________________ Date ______________________

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Atlanta Surgery Associates will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ______________________________ Date ____________________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Atlanta Surgery Associates. I agree to pay Atlanta Surgery Associates, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ______________________________ Date ____________________

FMLA Paperwork

FMLA forms or Short Term disability paperwork needs to be given to us at least 5 days in advance of your surgery. There is also a charge of $50 for ALL paperwork to be filled out that needs to be paid before we will complete. This fee is not billable to your insurance company. Additionally, any balance on your account must be paid prior to these forms being filled out.

Patient/Guarantor Signature______________________________Date____________________

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature ______________________________ Date ____________________

ATLANTA SURGERY ASSOCIATES

550 Peachtree St N. Ste 1430
Atlanta, GA 30308
Phone (404) 221-1095

1129 Hospital Dr. Ste. 1A
Stockbridge, GA 30281
(678) 289-5155

Protected Health Information Release Form:

Patient Name: ______________________________ Date: ________________

(1) Concerning matters of my health, I give permission for Atlanta Surgery Associates or a member of the staff to speak with:

Name of person(s) __________________ relationship to patient ________________

Name of person(s) __________________ relationship to patient ________________

Name of person(s) __________________ relationship to patient ________________

Name of person(s) __________________ relationship to patient ________________

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

____

____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

____

____

Signature of patient: ______________________________

Witness: ___________________________________