ATHENS GASTROENTEROLOGY PATIENT REGISTRATION FORM

Name: _____ Birthdate_____ Male___ Female ___

Soc.Sec#_____-_____-_____ Driver's Lic #_____Marital Status_____

Race _____ Ethnicity_____Preferred Language_____

Mailing Address_____City/State/Zip_____

Telephone_____ Cell_____ Referring Physician_____

Patient email address _____

Patient's
Employer _____

Address:_____City/State/Zip _____

Telephone:_____

Spouse / Parent Information

Name:_____Birthdate_____

Soc Sec#_____ Sex ___M ___F Telephone:_____

Address:_____City,State,Zip_____

Employer:_____ Phone # _____

In Case of Emergency Contact:

Name:_____Telephone_____

Primary Insurance Carrier:

Company Name:_____ Member ID#_____

Member Name:_____ Group #_____

Claim Address:_____Telephone#_____

Secondary Insurance Carrier:

Company Name:_____ Member ID #_____

Member Name:_____ Group #_____

Claim Address:_____ Telephone #_____

Patient Name:_____

Reason for the visit:_____

Other medical problems (i.e. high blood pressure, diabetes, hepatitis, depression, cancer): _____

_____

Past surgeries (including cardiac stents, pacemakers): _____

_____

_____

Allergies (including reaction):_____

Family medical History

Please circle if a family member has had the following:

Colon Polyps Colon Cancer Ulcerative Colitis Crohn's Disease

Preferred pharmacy (name & city):_____

Do you smoke/use tobacco products: Cigarettes Cigars Chewing Tobacco (please circle)

If you quit, list the year you quit _____ average pack per day_____

Do you use alcohol? Yes No (please circle one)

If yes, please circle one: Beer Wine Hard Liquor Amount Per day:_____

If you were unable to make medical decisions for yourself, who would you want to make those decisions on your behalf?

_____, Relationship:_____

List Medications: _____

_____

_____

_____

_____

_____

_____

_____

_____