David N. Socoloff, DO
Board Certified Gastroenterologist

NEW PATIENT INFORMATION

Phone 404-282-5600
Fax 404-282-5599

GastroCare
Physicians of Georgia

Patient Name: _____ **Date of Birth:** ____/ _____/ _____

Goes by: _____ **Sex Assigned at Birth:** ☐ **Male** ☐ **Female** **SS#**_____

Preferred Language: _____ **Race:** _____

Ethnicity: ☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino** ☐ **Prefer not to answer**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Street Address: _____**City:** _____**State:** _____**Zip:** _____

E-mail address: _____

Employment Status: ☐ **Employed** ☐ **Retired** ☐ **Unemployed** ☐ **Student**
Employer Name: _____

Mobile Phone (for texts & calls): (____**)** ____**-** _____**Alternate Phone: (** ____**)** ____**-** _____
☐ **OK to text** ☐ **Do NOT text**
Message/data rates may apply. Texts may include appointment reminders and limited health information.

Emergency Contact

Name: _____**Phone: (** ____**)** ____**-** _____**Relationship:** _____

Pharmacy Information

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address: _____

Mail-In Pharmacy (if applicable):_____

Insurance Information **(Bring with you to appointment)**

Self Pay: ☐

Primary Insurance

Insurance Company: _____
Subscriber Name: _____
Relationship to Patient: _____
Member ID: _____
Group #: _____

Secondary Insurance

Insurance Company: _____
Subscriber Name: _____
Relationship to Patient: _____
Member ID: _____
Group #: _____

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GastroCare
Physicians of Georgia

Patient Name: _____ **Date of Birth**: ___/ ____/ ____ **Age:** _____

Primary Care Physician: _____ **Referred by**:_____

Other Specialists: _____

Reason for visit: _____

Have you been to the ER or hospitalized for this problem? ☐ NO ☐ YES, and list below

Date _____ Hospital _____

Have you had any prior endoscopic procedures? ☐ NO ☐ YES, list below

Colonoscopy Date _____ Results/Findings _____

Upper GI (EGD) Date _____ Results/Findings _____

Past Medical History (Have you been diagnosed with any of the following)

☐ None

UPPER GI
☐ Barrett's esophagus
☐ Celiac Disease
☐ Esophageal
☐ Gastroparesis
☐ Ulcer
☐ Reflux/GERD

LOWER GI
☐ Colon polyps
☐ Colon Cancer
☐ Crohn's disease
☐ Diverticulitis
☐ Irritable Bowel Syndrome
☐ Lower GI bleed
☐ Ulcerative Colitis

LIVER/PANCREAS
☐ Abnormal liver
☐ Cirrhosis
☐ Hepatitis B
☐ Hepatitis C
☐ Pancreatitis

CARDIOVASCULAR
☐ Aortic Aneurysm
☐ Atrial fibrillation/irregular heartbeat
☐ Congestive Heart Failure (CHF)
☐ Coronary Artery Disease/Heart Stents/Heart Attack
☐ Heart murmur
☐ High blood pressure
☐ High cholesterol
☐ Defibrillator
☐ Pacemaker

RESPIRATORY
☐ Asthma
☐ Blood clot (DVT/PE)
☐ COPD/emphysema
☐ Obstructive sleep
☐ Home oxygen use
☐ Prior difficulty with anesthesia
☐ Prior difficult or failed intubation

RHEUMATOLOGIC
☐ Chronic back pain
☐ Fibromyalgia
☐ Lupus
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis

ENDOCRINE
☐ Diabetes
☐ Low thyroid

RENAL
☐ Chronic kidney
☐ ESRD/dialysis
☐ Kidney stones

HEMATOLOGIC
☐ Anemia
☐ Bleeding disorder
☐ HIV/AIDS
☐ Cancer: type
_____

NEUROLOGIC
☐ Dementia
☐ Migraine
☐ Parkinson's
☐ Seizures
☐ Stroke

PSYCHIATRIC
☐ Anxiety
☐ Bipolar
☐ Depression

GYNECOLOGIC
☐ Endometriosis

UROLOGIC
☐ Enlarged Prostate
☐ Interstitial cystitis

LIST ANY DIAGNOSES

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Patient Name: _____

Social History

Tobacco Use

☐ Never
☐ Former
☐ Current

If current or former:

- Type: ☐ Cigarettes ☐ Cigars ☐ Smokeless ☐ Vape/e-cig
- Amount: _____per
- Years used: _____
- Quit date (if former): _____/ _____/ _____

Alcohol Use

☐ None
☐ Occasional
☐ Moderate
☐ Heavy

If applicable:

- Type: _____
- Drinks per week: _____

Recreational Drug Use

☐ None
☐ Yes

If yes:

- Type: _____
- Frequency: _____

Living Situation

☐ Lives alone ☐ Lives with family ☐ Assisted living ☐ Other: _____

Functional Status (Pick One)

□ No Assistance needed □ Walks with Cane □ Walks with Walker □ Wheelchair bound □ Bed Bound

Implantable Devices

Do you have any implanted medical devices? ☐ No ☐ Yes (complete below)

Type of Device: _____
Model/Manufacturer (if known): _____
Date placed: _____/ _____/ _____
Location in body: _____

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Patient Name: _____

Family Medical History

☐ **None or No Known Family History**

Medical Condition							
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease (IBD)	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐

Other Significant Family History: _____

Allergies

☐ **No Known Drug Allergies**

Medication: _____ Reaction: _____ ☐ ☐ ☐

Medication: _____ Reaction: _____ ☐ ☐ ☐

Medication: _____ Reaction: _____ ☐ ☐ ☐

Medication: _____ Reaction: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Medication: _____ Reaction: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Medications

☐ **None**

Medication: _____ **Dose:** _____ **Frequency:** _____
Medication: _____ **Dose:** _____ **Frequency:** _____
Medication: _____ **Dose:** _____ **Frequency:** _____
Medication: _____ **Dose:** _____ **Frequency:** _____
Medication: _____ **Dose:** _____ **Frequency:** _____
Medication: _____ **Dose:** _____ **Frequency:** _____

Surgeries

Procedure / Surgery **Date** **Hospital (optional)**

_____
_____
_____
_____

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Patient Name: _____

Review Of Systems

Check symptoms you are currently experiencing:

GASTROINTESTINAL

☐ Abdominal pain
☐ Abdominal swelling
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Gas
☐ Heartburn
☐ Jaundice
☐ Loss of appetite
☐ Black Stool (Melena)
☐ Nausea
☐ Rectal bleeding
☐ Stomach cramps
☐ Vomiting

CONSTITUTIONAL

☐ Chills
☐ Fatigue
☐ Fever
☐ Night sweats
☐ Weight loss

CARDIOVASCULAR

☐ Chest pain or discomfort
☐ Palpitations
☐ Peripheral edema

GENITOURINARY

☐ Difficulty urinating
☐ Blood in urine
☐ Painful urination
☐ Abnormal menstrual
☐ Dark Urine
☐ Pregnant

☐ **None**

MUSCULOSKELETAL

☐ Joint pain
☐ Joint swelling
☐ Back pain

EYES, EARS, NOSE, THROAT

☐ Difficulty swallowing
☐ Hoarseness
☐ Throat pain

RESPIRATORY

☐ Cough
☐ Shortness of breath
☐ Wheezing
☐
☐ Use of CPAP
☐ Home oxygen use

SKIN

☐ Itching
☐ Rash
☐ Skin problems

NEUROLOGIC

☐ Dizziness/fainting
☐ Seizures
☐ Memory Loss
☐ Headache

PSYCHIATRIC

☐ Anxiety
☐ Depression

HEMATOLOGIC

☐ Easy bruising
☐ Easy bleeding
☐ Anemia

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Patient Privacy Questionnaire

Please list the family members or significant others, if any, whom we may inform about your care and your diagnosis (including treatment, payment, and health care operations) and in case of Emergency. This includes in person and over the phone:

Name: _____ **Name:** _____
Relationship: _____ Relationship: _____
Phone: _____ Phone: _____

Or

☐ **I do NOT authorize anyone to receive my medical information**

Patient Consent & Agreement

By signing below, I acknowledge and agree to the following:

I have reviewed and understand the **Notice of Privacy Practices**
I consent to **treatment and healthcare services**
I authorize **release of information for treatment, payment, and healthcare operations**
I understand and agree to the **Financial & Office Policy**
I consent to **electronic communication**, including phone, voicemail, patient portal, and (if selected) text messaging
I understand I may **revoke permissions in writing at any time**

Patient Name: _____

Signature: _____ **Date:** _____/ _____/ _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone 404-282-5600
Fax 404-282 5599

GastroCare
Physicians of Georgia

PATIENT INFORMATION

Patient's name: _____ Date of Birth: - /___/____

Address: _____

City/State/Zip Code: _____

Date of Request:_ /___/____

OR

☐ I authorize GastroCare Physicians of Georgia **to release** information to:

_____
Name of Provider or Facility

Phone: _____

Fax: _____

☐ I authorize GastroCare Physicians of Georgia **to .obtain** information from:

_____
Name of Provider or Facility

Phone: _____

Fax: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION INCLUDING, IF ANY, HIV, AIDS, PSYCHIATRIC, AND SUBSTANCE ABUSE

I **hereby authorize the above physician/hospital/facility to release information including, if any, psychiatric or psychological information, infections or contagious disease information (including HIV/AIDS) and/or information about drug or alcohol abuse or treatment of the same from the health record.**

I **understand** that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I **understand** that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I **understand** that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

To release my:

Last two office notes, recent Lab reports, Radiology Studies, and any pertinent records sent to you by other physicians for continuity of care.

Other as follows _____

_____

Patient Name: _____ Witness: _____

Patient/Legal Representative Signature: _____ Date: _____

Date: /___/____ Date at which this request will expire: _ /___/____

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Financial and Office Policy

1. **Collections and Returned Check Fee**- Should your check be returned by your bank due to insufficient funds or you stop payment on a check or credit card payment, you will be assessed a return payment fee of $35.00. Any unpaid balance that must be turned over to a collection agency will have a 33% collections fee added to the total balance due. You will be required to deal directly with the collection agency to reconcile the balance.
2. **No Show/Late Cancellation Fee-** We ask that the patient contact our office 24 hours prior to canceling an appointment. If three **(3)** no call/no shows occur, it may result in being discharged from our practice due to non-compliance. If you no show for a new patient visit, you may not be able to reschedule. **A charge of $50.00 will the patient's responsibility if you do not cancel within 24 hours. Failure to cancel an Endoscopy procedure within 48 hours may result in $100 fee or other pre-payments to hold future appointments.**
3. **Referrals and verification of Insurance-** If your insurance requires a referral, it is your responsibility to ensure this has been completed prior to being seen by our providers. It is the patient's responsibility to verify coverage and that we are in-network with your plan. Our billing office can assist you with any verification questions you may have.
4. **Non-Physician Practitioners-** Our clinic utilizes Physician Assistants to better assist with clinic appointments. They work under direct supervision with our physician at GastroCare Physicians of Georgia, and you may see them in conjunction with our provider for your office visits.
5. **Payment-** is due at the time of service, which may include all deductibles, coinsurance, copays, and past due balances. If your insurance carrier considers any service a non-covered service, or if you are paid directly by your insurance carrier, payment will be expected in full at the time of service. All payment arrangements must be approved by the Practice Administrator. Payment arrangements will only cover the specific charges and dates of service agreed upon. They will not cover additional charges or dates of service. We accept cash, check, money orders, American Express, Discover, MasterCard and VISA.

Patient Portal

For your convenience and best practice for protecting patient health information, we strongly encourage the patient portal set up. Help us eliminate the frustration of phone tag and utilize the patient portal. This is a secure portal where you can review your medical information, send messages, review messages, request refills, and pay your balance. We prefer to use this portal over regular email for security purposes.

Text Messaging (SMS) Consent

By providing a mobile phone number, you consent to receive text messages from the practice (via Klara or similar platform) for appointment reminders and care-related communication. Message and data rates may apply. Text messages may include limited health information and may not be fully secure. You may opt out at any time by replying STOP or by notifying our office.

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eRX Consent

e-Prescribing has been federally mandated that requires all physicians to prescribe medications electronically beginning in 2011. Prescriptions are sent over the internet to your pharmacy in a safe and secure way through the same technology used by credit card companies. This protects the privacy of your personal information.
e-Prescribing software also helps providers see important information like drug interactions and prescription history.

Privacy Notice

I acknowledge that I have been given a copy of the GastroCare providers "Notice of Privacy and/or have been informed where I can receive a copy. You may also find this directly on our at www.gastrocarega.com.

Permission For Treatment

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Gastrocare Physicians of Georgia deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Authorization And Assignment

I hereby authorize Gastrocare Physicians of Georgia to furnish information to Medicare/Insurance carriers concerning my medical conditions, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment directly to Gastrocare Physicians of Georgia for medical diagnostic surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks.
I have completed this form completely and certify that I am the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of all services provided.
I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.
I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.