

Patient Registration

(Please Print)

1. Chart Number _____
2. Patient's Full Name _____ 3. Sex: M F
Last First Middle Name Preferred
4. Race: (please circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined
Ethnicity: (please circle) Non-Hispanic, Hispanic, Patient Declined Preferred Language _____
5. Patient's Social Security # _____ 6. Date of Birth _____ Age _____
7. Patient's Home Address _____
Street or Route City State Zip
Patient's Email Address _____
8. Primary Care Doctor _____ 9. Financial Responsibility: Patient Other
10. Referring Doctor _____
11. Patient's Home Phone (____) _____ Patient's Work Phone (____) _____ Patient's Cell Phone (____) _____
Preferred Notification Method: (please circle) Postal Mail, Phone, Web Message
12. Is the Patient Currently Employed? Yes No
Patient's Employer _____
Employer's Address _____
Street or Route City State Zip
13. Patient's Marital Status S M D W Sep. Spouse Name _____
14. Person we may contact in case of an emergency: Relationship _____
Name _____ Telephone # _____
Address _____
Street or Route City State Zip

INSURANCE INFORMATION – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company _____ Address _____
16. Subscriber's Name _____ 17. Subscriber's Sex: M F
18. Subscriber's Date of Birth _____ 19. Subscriber's Social Security # _____
20. Patient's Relationship to the Subscriber Self Spouse Child Other
21. Subscriber's Employer _____
22. Subscriber's ID # _____ 23. Group # _____

SECONDARY INSURANCE COVERAGE

24. Insurance Company _____ Address _____
25. Subscriber's Name _____ 26. Subscriber's Sex: M F
27. Subscriber's Date of Birth _____ 28. Subscriber's Social Security # _____
29. Patient's Relationship to the Subscriber Self Spouse Child Other
30. Subscriber's Employer _____
31. Subscriber's ID # _____ Group # _____

OTHER INSURANCE Yes No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine, Wake Endoscopy Center and Wake Forest Endoscopy Center ("RMG/CMG/RAM/WEC/WF ENDO") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC/WF ENDO physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC/WF ENDO of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC/WF ENDO to the Patient. I understand that, to the extent permitted by applicable law, I am, and I agree hereby to be, financially responsible to RMG/CMG/RAM/WEC/WF ENDO for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC/WF ENDO on demand for all such charges.

Signature _____ Please check one: Patient Authorized Representative
Date _____ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC/WF ENDO to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC/WF ENDO to the Patient. I also hereby authorize RMG/CMG/RAM/WEC/WF ENDO to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _____ Please check one: Patient Authorized Representative
Date _____ Parent or Guardian of Minor

**Raleigh/Cary Medical Group GI – Wake Endoscopy Center
Patient History and Physical Form**

Date _____ Chart No: _____ *Please complete both sides*

Name _____ Birth date: _____ Age: _____

GI Physician _____ Referred by _____

Present Problem _____

Weight _____ Height _____ BMI: _____ Pregnant Yes / No

Preferred Language: _____ Translator needed: _____

Email address: _____ Preferred method of contact _____

Personal Health History

- | | | |
|------------------------------|----------------------------|--------------------------|
| _____ Diabetes | _____ COPD | _____ Seizures |
| _____ Cardiac Stents ___ yrs | _____ Asthma | _____ Stroke |
| _____ Heart Failure | _____ Inhalers Y/N | _____ Parkinson's |
| _____ Heart Attack | _____ Emphysema | _____ Muscular Dystrophy |
| _____ Heart Bypass x _____ | _____ Sleep Apnea CPAP Y/N | _____ Alzheimer's |
| _____ Pacemaker | _____ Home Oxygen | _____ Migraines |
| _____ Defibrillator | _____ High Blood Pressure | _____ Depression |
| _____ Heart Catherization | _____ Bleeding Disorder | _____ Anxiety |
| _____ Irregular Heart Beat | _____ Ulcers | _____ Kidney Disease |
| _____ Angina | _____ Reflux | _____ Dialysis |
| _____ Blocked Arteries | _____ Hepatitis A/B/C | _____ Crohn's Disease |
| _____ Heart Valve Replaced | _____ Joint Replacement | _____ Colitis |
| _____ Other | | |

Past complications with sedation: No / Yes List Complications: _____

Fear of Needles: No / Yes Difficulty obtaining IVs No / Yes

Do you currently smoke: No / Yes # packs/day _____ Former Smoker: No / Yes

Recreational Drugs: No / Yes _____ Drink alcohol: No / Yes Socially _____ Amount _____

Immunizations: Flu vaccine No / Yes _____ Pneumonia vaccine No / Yes _____

Surgeries _____

Disabilities _____

Colonoscopy No / Yes _____ date; EGD No / Yes _____ date; Mammogram No / Yes _____ date

History of polyps: Self: No / Yes _____ age; Family No/ Yes _____ Relationship _____ age

Personal or family history of: (list self or relationship of family member and age)

- | | |
|-----------------------------------|---------------------------------|
| Colorectal Cancer _____ | Stomach/Esophageal Cancer _____ |
| Breast Cancer _____ | Kidney/Ureter Cancer _____ |
| Endometrial/Uterine/Ovarian _____ | Pancreatic/Biliary Cancer _____ |
| Small Bowel Cancer _____ | Brain/Sebaceous Adenomas _____ |

Patient: _____

Chart: _____

Latex allergy: No / Yes Reaction _____

Allergy to eggs or soy beans: No / Yes Reaction _____

Allergies:	Drug: _____	Reaction _____
	Drug: _____	Reaction _____
	Drug: _____	Reaction _____
	Drug: _____	Reaction _____
	Drug: _____	Reaction _____
	Drug: _____	Reaction _____
	Drug: _____	Reaction _____

Present Medications: (List over the counter and Herbal Meds also)

CURRENT PHARMACY _____

(Nurse to complete)

Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____
Drug: _____	Dose: _____	Date/Time Last Taken: _____

Hx/Medications Reviewed by Endo Nurse: _____

Date: _____



RMG Gastroenterology

A DIVISION OF RALEIGH MEDICAL GROUP, P.A.
www.rmggastroenterology.com



Wake Endoscopy Center, LLC

www.wakeendoscopy.com

Raleigh Medical Group Gastroenterology
2601 E. Lake Drive, Suite 201, Raleigh, NC 27607
Telephone 919-783-4888 Fax 919-783-4887

RMG Gastroenterology of Wake Forest
11200 Governor Manly Way, Suite 200, Raleigh, NC 27614
Telephone 919-562-6589 Fax 919-562-7034

Hutzenbuhler Gastroenterology
3200 Blue Ridge Road, Suite 226, Raleigh, NC 27612
Telephone 919-787-7226 Fax 919-787-4226

Cary Medical Group Gastroenterology
530 New Waverly Place, Suite 314, Cary, NC 27518
Telephone 919-858-0892 Fax 919-342-3472

RMG Gastroenterology of Clayton
2076 NC Hwy. 42 W., Suite 100, Clayton, NC 27520
Telephone 919-783-4888 Fax 919-783-4887

Effective April 14, 2003, a new federal regulation, known as "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. Attached is a SUMMARY OF NOTICES OF PRIVACY PRACTICES for Wake Endoscopy Center, a division of Raleigh Medical Group. An authorization instructing our office on how to communicate with you about any healthcare information pertaining to your treatment and billing information is also included. **Please read, complete, and sign all attached authorization according to your preference(s).**

If your appointment is scheduled at Wake Endoscopy Center, please bring all completed HIPAA authorization forms along with your completed registration forms and insurance cards to your appointment. PLEASE DO NOT MAIL REGISTRATION FORMS TO OUR OFFICE.

If your procedure is scheduled at the hospital, only the completed/signed HIPAA authorization forms back to our office to the address listed below:

Raleigh Medical Group
Wake Endoscopy Center
2601 E. Lake Drive, Suite 201
Raleigh, NC 27607

If your procedure is scheduled at the hospital, please complete the enclosed medical forms for the facility where your procedure is scheduled and take with you on the day of your procedure. Do not mail the hospital forms back to Wake Endoscopy Center, as the hospital will need this paperwork.

If you have any questions please call (919) 783-4888.

Michael P. Battaglino, M.D.
Subhash C. Gumber, M.D., Ph.D.
Angela N. Hutzenbuhler, M.D.

Indira Reddy, M.D.
Neeraj K. Sachdeva, M.D.
Christopher J. Schwarz, M.D., Ph.D.

Ronald P. Schwarz, M.D.
Kerry Whitt, M.D.
Cindy Groce, GI Administrator

All physicians are board certified in Gastroenterology and Hepatology.



Wake Endoscopy Center, LLC

2601 E. Lake Drive, Suite 201

Raleigh, NC 27607

Telephone 919-783-4888 Fax 919-783-4887

Chart #: _____ Date: _____

I give my permission for the providers of Raleigh Medical Group, P.A. to release **ANY** information about my medical condition, prescriptions, and financial account to:

Name: _____

Name: _____

Name: _____

Below, I give my permission for the providers of Raleigh Medical Group, P.A. to release prescriptions and samples **ONLY** to:

Name: _____

Name: _____

Name: _____

The above mentioned person(s) **will be required to provide photo ID** when picking up requested items.

Patient name: _____ DOB: _____

Patient signature: _____

By signing on the line below, I acknowledge that I was provided access to Privacy Practices of Raleigh Medical Group, P.A.:

Print Name: _____ DOB: _____

Patient Signature: _____

For Personal Representation of the patient (if applicable)

Print Name of Personal Representative: _____

Representative's Relationship (i.e. parent/guardian/other, etc.): _____

Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Raleigh Medical Group, P.A.

Signature of Practice Employee

Date



Wake Endoscopy Center, LLC

Summary of Notice of Privacy Practices

Effective Date: April 14, 2003

DESCRIPTION OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. FOR ADDITIONAL INFORMATION, PLEASE REFER TO THE FULL VERSION OF THIS NOTICE OR CONTACT OUR PRIVACY OFFICER.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use or disclose your health information:

- To treat you;
- To get paid for treating you;
- To run the practice;
- To remind of you of appointments; and
- As may be required or otherwise permitted by law.

For more information on how we may use or disclose your health information, please refer to the full version of the Notice or contact our Privacy Officer.

We will use or disclose your health information for other purposes only with your authorization. If you authorize us to disclose your protected health information for other purposes, you may revoke that authorization at any time by notifying us.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the right to:

- Ask us to limit the information that we share;
- Receive confidential communications from us regarding your health information;
- Look at and obtain a copy of your health information;
- Amend mistakes in your health information;
- Obtain a list of disclosures of your health information that we have made; and
- Obtain a copy of the full version of our Notice of Privacy Practices.

For more information on how to exercise your rights and how such rights may be limited by law, please refer to the full version of this Notice or contact our Privacy Officer.

OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties with respect to your protected health information and our privacy practices, and to abide by the terms of our Notice of Privacy Practices.

REVISIONS TO NOTICE OF PRIVACY PRACTICES

We may revise our policies with respect to the privacy of patient health information from time to time. Any amendments to our Notices shall be posted in our offices, and copies of any amended Notice will also be available in our offices.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. For more information on how to file a complaint, please refer to the full version of this Notice or contact our Privacy Officer.

PRIVACY OFFICER CONTACT INFORMATION

If you have any questions regarding your privacy rights, please refer to the full version of this Notice or contact our Privacy Officer at (919) 859-5955. You also may address questions or concerns to the Privacy Officer by writing to: Dr. Sylvia Shoffner, 530 New Waverly Place, Suite 314, Cary, NC 27518