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
____ Cardiac Stents __yrs
____ Heart Failure
____ Heart Attack
____ Heart Bypass x___
____ Pacemaker
____ Defibrillator
____ Heart Catherization
____ Irregular Heart Beat
____ Angina
____ Blocked Arteries
____ Heart Valve Replaced
____ Other

____ COPD
____ Asthma
____ Inhalers Y/N
____ Emphysema
____ Sleep Apnea CPAP Y/N
____ Home Oxygen
____ High Blood Pressure
____ Bleeding Disorder
____ Ulcers
____ Reflux
____ Hepatitis A/B/C
____ Joint Replacement

____ Seizures
____ Stroke
____ Parkinson's
____ Muscular Dystrophy
____ Alzheimer's
____ Migraines
____ Depression
____ Anxiety
____ Kidney Disease
____ Dialysis
____ Crohn's Disease
____ Colitis

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:** _________________
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Drug: ____________________ **Dose:** __________ **Date/Time Last Taken:** _________________
Drug: ____________________ **Dose:** __________ **Date/Time Last Taken:** _________________

Hx/Medications Reviewed by Endo Nurse: ____

Date: __________________

Revised S Parrish RN 2/28/14

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 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 301, Cary, NC 27518
Telephone 919-858-0892 Fax 919-342-3472

RMG Gastroenterology of Clayton
900 S. Lombard Street, Suite 106, Clayton, NC 27520
Telephone 919-341-3638 Fax 919-359-6290

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. <u>PLEASE DO NOT MAIL REGISTRATION FORMS TO OUR OFFICE.</u>

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

Wake Endoscopy Center, LLC
Raleigh Medical Group Gastroenterology
(Division of Raleigh Medical Group, P.A.)
2601 Lake Dr., Ste. 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. <u>Do not mail the hospital forms back to Wake Endoscopy Center/Raleigh Medical Group Gastroenterology, as the hospital will need this paperwork.</u>

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

WAKE ENDOSCOPY CENTER. LLC
RALEIGH MEDICAL GROUP GASTROENTEROLOGY
(A Division of Raleigh Medical Group, P.A.)
2601 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

Revised 2/2018

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 out 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 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. Foe 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