

**Memphis Gastroenterology Group  
PATIENT REGISTRATION FORM**

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ (optional)

Race

Caucasian	<input type="checkbox"/>	Asian	<input type="checkbox"/>
African	<input type="checkbox"/>	Other	<input type="checkbox"/>
American	<input type="checkbox"/>		
Hispanic	<input type="checkbox"/>		

Language

English	<input type="checkbox"/>
Spanish	<input type="checkbox"/>
Other	<input type="checkbox"/>

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ ext \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you retired? Yes \_\_\_ or No \_\_\_ Are you married? \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced \_\_\_

Who is your primary care or family physician? \_\_\_\_\_

What doctor referred you? \_\_\_\_\_

What is the name of your pharmacy? \_\_\_\_\_

Pharmacy phone # \_\_\_\_\_ Address \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell # \_\_\_\_\_

**SPOUSE INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ (optional) Race \_\_\_\_\_ Language \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ ext. \_\_\_\_\_

Cell phone \_\_\_\_\_

Is Spouse or resp. party employed? Yes \_\_\_\_\_ NO \_\_\_\_\_

Employer's Name and Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

OVER 

**INSURANCE INFORMATION**

DO YOU HAVE MEDICARE?

YES

NO

If YES

TRADITIONAL MEDICARE

MEDICARE ADVANTAGE

IS MEDICARE PRIMARY? YES / NO

If YES, GIVE MEDICARE # \_\_\_\_\_

DO YOU HAVE MEDICAID? YES/ NO. IF SO, GIVE MEDICAID # \_\_\_\_\_

**PRIMARY INSURANCE**

NAME OF INSURANCE \_\_\_\_\_ GROUP # \_\_\_\_\_ POLICY # \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

WHERE DO WE SEND CLAIM(S) \_\_\_\_\_

Does this policy require a referral in advance? YES / NO

PHONE NUMBER TO VERIFY (     ) \_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURANCE \_\_\_\_\_ GROUP # \_\_\_\_\_ POLICY # \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

WHERE DO WE SEND CLAIM(S) \_\_\_\_\_

Does this policy require a referral in advance? YES / NO

PHONE NUMBER TO VERIFY (     ) \_\_\_\_\_

**Does your insurance plan require you to use a special hospital or lab for outpatient surgeries,  
x-ray or lab work? YES / NO**

**IF YES, Which hospital or Lab? \_\_\_\_\_**

NAME: \_\_\_\_\_

REVIEW OF SYSTEMS

DATE: \_\_\_\_\_ (Circle any of the following that apply to you)

**Constitutional**

Weight Gain  
Weight Loss  
Fever  
Malaise  
Fatigue  
Chills/Rigors  
Night Sweats

**HEENT**

Headache  
Double Vision  
Eye Pain  
Sensitivity to Light  
Vision Loss  
Glasses or Contacts  
Hearing loss  
Ear Pain  
Nasal Congestion  
Nosebleeds  
Decreased Smell  
Frequent sore throats  
Hoarseness  
Change in Taste

**Respiratory**

Shortness of Breath  
Cough  
Chest Pain with breathing  
Asthma (Wheezing)

**Cardiovascular**

Chest Pain  
Hypertension  
High Cholesterol  
Peripheral Vascular Disease  
Palpitations  
Swelling of Feet (Edema)  
Heart Murmur

**Gastro/Liver**

Loss of Appetite  
Gallstones  
Nausea  
Vomiting  
Vomiting Blood  
Diarrhea  
Constipation  
Black/Tarry Stools  
Blood from Rectum  
Change in Bowel Habits  
Abdominal pain  
Ulcer disease  
Difficulty Swallowing  
Reflux  
Indigestion/Heartburn  
Liver Disease  
Rectal Pain  
Distension  
Colon Polyps

**Urinary**

Frequent Urination  
Painful Urination  
Blood in Urine  
Kidney Stones  
Frequent Urination at Night  
Dark urine  
Urinary Incontinence

**Reproductive**

(Women Only)  
Pregnant (yes, no, maybe)  
Breast Disease  
Sexual Problem

(Men Only)

Prostate Disease  
Prostate Cancer  
Sexual Problems

**Metabolic/endocrine**

Heat/Cold Intolerance  
Change in Hair  
Frequent Urination  
Diabetes  
Thyroid Disease  
Excessive Thirst

**Neuro/psychiatric**

Headache  
Vertigo (dizziness)  
Seizures  
Loss of Consciousness (fainting)  
Tremors  
Numbness  
Depression  
Stroke  
Nervousness  
Physical/Sexual/Spousal abuse  
Gait Disturbance  
Memory Loss

**Skin**

Rash  
Lesions (nodules/sores/ulcers)  
Easy Bruising  
Nail Changes  
Acne  
Itching

**Musculoskeletal**

Swelling  
Redness  
Arthritis  
Gout

**Hematologic**

Anemia/low white count/low platelets  
Easy Bruising  
Easy Bleeding  
Thromboembolic events (blood clots)  
Swollen Lymph Nodes

**Allergy/Immunologic**

Asthma  
Hayfever  
Hives  
Allergies

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

REVISED  
5/25/2006



# Memphis Gastroenterology Group & Memphis Gastroenterology Endoscopy Center East

[www.memphisgastro.com](http://www.memphisgastro.com)

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Administrator

## OFFICE POLICY ON MANAGED CARE INSURERS

Memphis Gastroenterology Group, P.C. and Memphis Gastroenterology Endoscopy Center East has enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations, we must rely on you, the patient, to inform us EACH time of service exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as **lab work, screening/preventive care, hospitalization, and/or out-patient-procedures** that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.



I have read and understand the office policy stated above and agree to accept responsibility as described.

8000 Wolf River Boulevard  
Suite 200  
Germantown, Tennessee 38138

901 747-3630  
901 747-4149 fax

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize MGG/MGECE  
Yes No to leave a message regarding  
pending appointments or test at  
my residence.

It is ok to leave a message with my employer.  
Yes No

It is ok to leave a message with any of the family members listed below:  
Yes No

Family Member: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Family Member: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Family Member: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Family Member: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian Relationship

## CONSENT FOR CARE

I hereby give my consent for treatment to Memphis Gastroenterology Group, P.C. & Memphis Gastroenterology Endoscopy Center East.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian Relationship

## AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to MGG/MGECE for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in an attempt to collect said balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian Relationship

## LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to MGG/MGECE for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian Relationship

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed October, 2002.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian Relationship

Please initial that you have received a patient brochure and a copy of your rights & responsibilities.

\_\_\_\_\_  
Initials

**Family / Social History**

Birthplace \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you-      Single              Married              Divorced              Separated              Widowed

Do you have children?      Yes      No      \_\_\_ Sons      \_\_\_ Daughters

Have you ever had any type of cancer?      Yes      No      What type? \_\_\_\_\_

Do you have a defibrillating pacemaker? \_\_\_\_\_      What type? \_\_\_\_\_

Do you use a C-Pap Machine? \_\_\_\_\_

Have you had a heart valve replaced? \_\_\_\_\_

Do you take any appetite suppressants? \_\_\_\_\_

Do you wear dentures? \_\_\_\_\_

Do you smoke?      Yes      No      If so, how much? \_\_\_\_\_

Do you drink alcohol?      Yes      No      If so, how much? \_\_\_\_\_

Do you drink caffeine?      Yes      No

Do you have a Living Will for healthcare?      Yes      No

**Previous Surgery or Hospitalization**

Type              Approximate Year

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Chronic Medical problems:**

\_\_\_\_\_  
\_\_\_\_\_

**Family History**

**Family Member**

Ulcer Disease \_\_\_\_\_

Gallbladder Disease \_\_\_\_\_

Inflammatory Bowel Disease \_\_\_\_\_

Heart Disease \_\_\_\_\_

Diabetes \_\_\_\_\_

Colon Polyps \_\_\_\_\_

Pancreatitis \_\_\_\_\_

Liver Disease \_\_\_\_\_

Has anyone in your immediate family ever had cancer? \_\_\_\_\_

If so, please list which relatives and types of cancer:

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

