ATLANTA CENTER FOR GASTROENTEROLOGY, P.C.
ATLANTA ENDOSCOPY CENTER, LTD.
404-296-1986

David B. Rausher, M.D. – Cliff Parrish, M.D.

PLEASE PRINT THE FOLLOWING:

LAST NAME:_____ FIRST:_____

ADDRESS:_____
(Street) (City, State) (Zip) (County)

Billing Address (if other than above)

_____

Marital Status: ____S ____M ___D ___W Race_____ Sex _____ E-mail Address_____

Home Phone: ( )_____ Work Phone: ( )_____ other_____

Date of Birth:_____ Age_____ Male ☐ Female ☐ Social Security#:_____

Employer:_____
(Name) (Street) (City/State/Zip)

Occupation:_____ Birthplace_____ Religion_____

Spouse Name_____ Date of Birth:_____ Spouse Work Phone_____

PERSON RESPONSIBLE FOR CHARGES; IF OTHER THAN PATIENT

Name:_____ Relationship_____

Address:_____

Home phone ( )_____ Work phone ( )_____

NOTIFY IN CASE OF EMERGENCY (PERSON NOT LIVING WITH YOU)

Name:_____ Relationship_____

Address:_____
(Street) (City/State/Zip)

Home phone ( )_____ Work phone ( )_____

REFERRED BY DOCTOR:_____ PHONE #:_____

FAMILY DOCTOR:_____ GYN DOCTOR_____

PHARMACY NAME AND PHONE NUMBER_____

TODAY'S DATE:

ATLANTA CENTER FOR GASTROENTEROLOGY, P.C.
ATLANTA ENDOSCOPY CENTER, LTD.

The following authorizations must be signed by the patient or guardian before any insurance forms or medical reports can be released from this office.

I authorize the **Atlanta Center for Gastroenterology, P.C.** or the **Atlanta Endoscopy Center, LTD**. To disclose complete information to any insurance company or individual having just cause to request such information concerning the medical findings and treatment, including copies of records. I also understand that if my insurance company requires a referral, it is my responsibility to obtain that referral prior to my visit. If a referral is not obtained, I may reschedule my appointment until a referral is obtained, or I may pay the charges for my services at the end of the visit.

Does your insurance company require a referral? Yes_____ No_____

X_____ X_____ X_____
Print Name Signature Date

I authorize payment directly to the **Atlanta Center for Gastroenterology, P.C.** or the **Atlanta Endoscopy Center LTD**. Of surgical medical benefits payable under the provisions of my policy. I understand that I am financially responsible for any amount not covered by my insurance.

X_____ X_____ X_____
Print Name Signature Date

I give my consent for Dr._____, and his/her assigned staff to provide medical examination, assessment, care and treatment to me.

X_____ X_____ X_____
Print Name Signature Date

I give my consent for Dr. _____, and his/her assigned staff to retrieve the list of my current medications from my pharmacy

X_____ X_____ X_____
Name Signature Date

ATLANTA CENTER FOR GASTROENTEROLOGY,P.C

2665 N. DECATUR RD #550

DECATUR,GA.30033

PHONE# 404-296-1986

FAX# 404-296-9890

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: X _____ Date of Birth: _____

Previous Name: _____ Social Security# _____

I consent and authorize , Atlanta Center for Gastroenterology,P.C. _____ to

Release Healthcare and /or Financial information to :

Name(s) _____

Realntionship: _____

Phone: _____

Please provide info for the person we can speak with on your behalf about your health and financial information, if you are unavailable.
EX: Spouse, children, friend etc

This consent and authorization applies to:

☐ Healthcare Information relating to the following treatment,condition,or dates:

_____

_____

☐ All Healthcare information

☐ Other: _____

☐ Financial Infromation

Definition: **Sexually Tansmitted Disease (STD) as defined by law,RCW 70.24 et seq.,herpes, herpes simplex, human papilloma virus,wart,genital wart, condyloma, Chlamydia, non-specific urethritis,syphllis,VDRL chancroid, lymphogranuloma venereum, HIV(Human Immunodeficiency Virus) AIDS, (Acquired Immunodeficiency Syndrome) and gomorrhea.**

☐ Yes ☐ No **I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s listed above will be notified that I must give specific written permission before disclosure of test results to anyone.**

☐ Yes ☐ No **I authorize the release of any records regarding drug, alcohol, or mental health treatment to the Person(s) listed above.**

Patient Signature : X _____ Date signed: _____

Print Name: X _____

Atlanta Center for Gastroenterology, P.C
2665 North Decatur Road #550, Decatur, GA 30033
(Fax) 404-296-9890 (Phone) 404-296-1986

Authorization and Consent to Release Medical Information

By signing this authorization, I give permission to disclose the following Protected Health Information (PHI) to Atlanta Center for Gastroenterology, P.C.

Request a copy of my medical records from:

Doctor / Practice: _____

Address: _____
(City) (State) (Zip)

Office Phone #: _____ Fax #. _____

X Patient Name: _____
(First) (Middle Initial) (Last)

X Patient Date of Birth: _____ X Day Time Phone #_____

Date of Records/ From_____ To _____

Type of Information requested:

All Records	☐	Lab Reports	☐	Hospital Admissions	☐
EKG'S	☐	X-Rays	☐	Hospital Discharge/ Summaries	☐
Recent Procedures	☐	Pathology Reports	☐	Operative Reports	☐

The Information will be used for the following purpose:

_____ Medical _____ Legal Actions _____ Other _____
(Please Specify)

I realize that my records contain confidential and / or privileged information. Based on this knowledge, I give my consent to have my records released as requested.

X _____ X _____
(Patient's Signature) (Date)

COVID-19 SCREENING

PATIENT NAME: _____ DATE: _____

DOB : _____/_____/_____ PHONE # _____

PLEASE ANSWER THE QUESTIONS BELOW:

HAVE YOU TRAVELED WITHIN THE LAST 14 DAYS OR HAD CONTACT WITH SOMEONE WHO HAS?

YES _____ NO _____

HAVE YOU BEEN DIAGNOSED WITH COVID-19 ?

YES _____ NO _____

HAVE YOU HAD CONTACT WITH A PERSON DIAGNOSED WITH COVID?

YES _____ NO _____

HAVE YOU RECEIVED A COVID-19 VACCINATION/BOOSTER?

YES _____ NO _____ IF YES, HOW MANY? _____

ARE YOU CURRENTLY EXPERIENCING THE BELOW SYMTOMS,

PLEASE CHECK ALL THAT APPLY.

FEVER ___ SHORTNESS OF BREATHE ____ COUGH ____ CHILLS/SHAKING ____

SORE THROAT ____ MUSCLE PAIN _____ LOSS OF SMELL/TASTE _____

IF THE PATIENT ANSWERS YES TO ANY OF THE QUESTIONS, NOTIFY MD

Revised 01/2015/MB

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LIST ANY DRUG ALLERGIES YOU MAY HAVE:_____

LIST ANY HOSPITALIZATION AND SURGERIES YOU HAVE HAD AS WELL AS WHEN THEY WERE DONE:

_____

_____

_____

Describe any special Diet you are on:_____

Caffeine intake ☐ YES ☐ NO How Much? _____

Do you smoke? ☐ YES ☐ NO How Much? _____

Do you drink alcohol? ☐ YES ☐ NO How Much? _____

Do YOU have any of the following?				**Is there a FAMILY HISTORY of these?**		
Ulcerative colitis	☐ YES	☐ NO	→	☐ YES	☐ NO	Who?_____
Crohn's disease	☐ YES	☐ NO	→	☐ YES	☐ NO	Who?_____
Colon Polyps/Cancer	☐ YES	☐ NO	→	☐ YES	☐ NO	Who?_____
Other Cancer	☐ YES	☐ NO	→	☐ YES	☐ NO	Who?_____
Hepatitis/Jaundice	☐ YES	☐ NO		☐ YES	☐ NO	Who?_____
Heart Murmur	☐ YES	☐ NO				
Diabetes	☐ YES	☐ NO				
Nausea/Vomiting	☐ YES	☐ NO				
Early fullness after eating	☐ YES	☐ NO				
Celiac/Sprue disease	☐ YES	☐ NO				
Stomach Ulcers	☐ YES	☐ NO				
Stomach Pain	☐ YES	☐ NO				
Difficulty Swallowing	☐ YES	☐ NO				
Food getting stuck	☐ YES	☐ NO				
Heartburn	☐ YES	☐ NO				
Constipation/diarrhea	☐ YES	☐ NO				
Anemia	☐ YES	☐ NO				
Blood in stool	☐ YES	☐ NO				
Blood in Urine	☐ YES	☐ NO				
Depression/anxiety	☐ YES	☐ NO				
Change in weight/fatigue	☐ YES	☐ NO				
Chest pain	☐ YES	☐ NO				
Strokes/seizures	☐ YES	☐ NO				
Rheumatic fever	☐ YES	☐ NO				
Hypertension	☐ YES	☐ NO				
AIDS HIV +	☐ YES	☐ NO				
Frequent headaches	☐ YES	☐ NO				
Lung disease	☐ YES	☐ NO				
Joint or back pain	☐ YES	☐ NO				
Ear, nose, throat disease	☐ YES	☐ NO				
Skin rash/itching	☐ YES	☐ NO				
Kidney disease/stones	☐ YES	☐ NO				
Glaucoma/vision problems	☐ YES	☐ NO				

Have you had these Vaccines ?			**Date of Vaccine**
Flu Vaccine	☐ YES	☐ NO	_____
Pneumovax	☐ YES	☐ NO	_____
Hepatitis A Vaccine	☐ YES	☐ NO	_____
Hepatitis B Vaccine	☐ YES	☐ NO	_____
Shingles Vaccine	☐ YES	☐ NO	_____

X_____
Patient Name

X_____
Signature

_____
Date

Reviewed by physician:
Initials Date
_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

ATLANTA CENTER FOR GASTROENTEROLOGY, PC

PLEASE PROVIDE A CURRENT MEDICATION LIST ALONG WITH CURRENT DOSAGE AND FREQUENCY

PATIENT NAME: X________________________________

DATE:_____________________________________
