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:** ____________
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
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. 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.
Sanjay Jagannath, M.D., AGAF, FASGE
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

Rev 8/12

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