Patient Registration Form

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

Date of Birth: _____ Social Security Number: _____ Marital Status: _____

Sex: Male or Female (circle one) Race: _____ Ethnicity: _____

Mailing Address: _____

City: _____State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Employer Name: _____ Phone: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____ Phone: _____

Emergency Contact (not living with you): _____

Relationship: _____ Phone: _____

Primary Care Provider: _____ Referring Provider (if different): _____

Insurance Information

Primary Insurance Co: _____ Secondary Insurance Co: _____

Policy Number: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber SSN: _____

In order for your insurance to be filed by this office we must have your signature for our file. Please sign the authorization below.

I hereby authorize the payment of medical benefits to be made directly to Metro Surgical, PC for services rendered to myself or my dependents. I understand that I am responsible for making sure that the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment.

I authorize Metro Surgical, PC physicians to examine me and render medical or surgical care as he/she deems necessary.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS; formerly HCGA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Patient Signature: _____Date: _____

Patient History & Physical

Patient Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Reason for visit:
_____

List all medications currently taking:
_____
_____

List any drug allergies:
_____
_____

List any operations and when they took place:
_____
_____
_____

Have you ever been hospitalized for reasons other than surgery? Please describe:
_____
_____

List any diseases that run in your family:
_____
_____

Do you smoke? Yes or No
Former smoker? Yes or No Quit MM/YY: _____
Do you drink alcohol? Yes or No
How often? _____

Pharmacy Name & Telephone: _____
_____

Have you traveled outside of the U.S. within the last 12 months? Yes or No If yes, when? _____

Have you received a flu vaccine? Yes or No If yes, when? _____

Have you received a pneumonia vaccine? Yes or No If yes, when? _____

Have you received the COVID-19 vaccine(s)? Yes or No If yes, list month/year of each dose. _____
_____

*Brand of COVID-19 vaccine(s) received; i.e., Moderna, Pfizer, etc.: _____

Have you had or do you currently have any of the following conditions? Please circle any that apply.

Aids or HIV	Heart Disease	Irregular Heart Beat	Liver Disease
Lung Disease	High Blood Pressure	Stomach Disease	Intestinal Disease
Bleeding Tendency	Anemia	Epilepsy	Kidney Disease
Cancer (type) _____	Hepatitis (type) _____	Pregnancies # _____	Other _____

Family History

Relationship	Age	Living	Dead	Cause of Death	Major Disease
Father					
Mother					
Brother					
Sister					

Is there anything else you feel the doctor should know? Please describe: _____
_____
_____

Signature: _____ Date: _____

Colonoscopy Insurance Statement

Please be advised every insurance company is different. While we do our best to verify your benefits, it is your responsibility to know your insurance policy and benefits. Many insurance companies offer SCREENING colonoscopies covered at 100%. By circling any of the following symptoms your colonoscopy will be considered a diagnostic colonoscopy and not a screening. If you are scheduled to have a routine screening colonoscopy and your surgeon discovers any polyps, masses, etc. and/or performs biopsies—YOUR INSURANCE may consider the procedure to be diagnostic, rather than a screening, which could affect the covered benefit amount.

Circle any symptoms you are CURRENTLY experiencing.

Rectal pain	Rectal bleeding	Rectal discharge	Nausea
Diarrhea	Constipation	Change in bowel habits	Vomiting
Abdominal pain	Unexplained weight loss	Blood in stool	Fever

Personal / Family History

Personal history of colon polyps		Personal history of Crohn's Disease			
Personal history of colon cancer		Personal history of Ulcerative Colitis			
Family history of colon polyps	(**Circle any applicable**)	Mother	Father	Brother	Sister
Family history of colon cancer	(**Circle any applicable**)	Mother	Father	Brother	Sister

Previously performed procedures (if applicable).

Colonoscopy	MM/YYYY: _____ Results: _____
Flexible Sigmoidoscopy	MM/YYYY: _____ Results: _____
Barium Enema	MM/YYYY: _____ Results: _____

By signing below, you agree to pay for any services and/or charges that are not covered by your insurance plan (including amounts applied toward your deductible).

_____ _____

Print Patient Name Date of Birth Patient Signature Date

Patient Consent for Use/Disclosure of Health Care Information

Patient Name: _____ DOB: _____ SSN: _____

Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Metro Surgical, PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Metro Surgical, PC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Metro Surgical, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the notice before signing this agreement.

Metro Surgical, PC may update this "Notice of Privacy Practices". If I ask, Metro Surgical, PC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I may ask Metro Surgical, PC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or other health care operations. I understand Metro Surgical, PC does not have to agree with my request. If Metro Surgical, PC does agree with my request, I understand Metro Surgical, PC will follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1. Sign and date a form that Metro Surgical, PC will provide, named "Revocation of Consent for Use and Disclosure of Health Care Information"; or

2. Write, sign, and date a letter to Metro Surgical, PC. If I write a letter, it must state that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and all other health care operations.

If I revoke this consent, Metro Surgical, PC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the opportunity to review a current copy of Metro Surgical, PC's "Notice of Privacy Practices". My signature means that I agree to allow Metro Surgical, PC to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient (If signed by legal representative)

Patient Record of Disclosure

In general, the HIPAA privacy rules give the individuals the right to request a restriction on uses and disclosures of protected health information and electronic protected health information.

I wish to be contacted in the following manner (please check all that apply).

____ Home Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Cell Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Work Phone _____

____ Leave a message with detailed information

____ Leave a message with callback number only

____ Written Communication

____ Mail to my home address

____ Mail to my work address

You may leave a message with, discuss my treatment, appointment, or other scheduling that may occur with the following family member, friend or personal representative(s). I understand that by giving authorization to the representative(s) listed below, they will have complete access to my electronic medical record. I understand Metro Surgical, PC will refuse to discuss my information with anyone **not** listed below, except in emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT (family member, friend or personal representative(s))

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

_____ _____

Print Patient Name Date of Birth Patient Signature Date

FollowMyHealth Online Registration Form

Access your medical information on the go! Download the free portal app at your Apple or Android store. FollowMyHealth is not monitored by staff members daily. If you have any questions or concerns, please contact our office at (912) 826-4057. Do not send any messages through the portal, we will not see it.

Check one:

☐ I decline account access on the FollowMyHealth online application for Metro Surgical, PC.

☐ I wish to set up account access on the FollowMyHealth online application for Metro Surgical, PC. ***I understand FollowMyHealth is not monitored daily and agree to contact the office via telephone with any questions or concerns***.

My email address (required for access) is: _____@_____

Print Patient Name Date of Birth Patient Signature Date