Knoxville Gastrointestinal Specialists Registration Form

Patient's First Name	Middle Initial	Last name	Birthdate	Age

Address	Apt #	City	State	Zip Code

Social Security #	Sex	Marital Status	Email Address

Home Phone #	Mobile Phone #	Preferred contact number: ☐ Home ☐ Mobile	Preferred contact method: ☐ Voice ☐ Text ☐ Email

Employer's Name, Phone Number, Occupation	Do you have any of the follwing: ☐ Living Will ☐ Medical Power of Attorney

Referring provider	Phone Number

Primary Care Physician	Phone Number

Preferred Pharmacy	Address	Phone Number

Insurance Information

Primary Insurance Name		Subscriber ID #	Group #
Subscriber Name	Subscriber Birthdate	Subscriber Social Security #	Relationship to patient
Secondary Insurance Name		Subscriber ID #	Group #
Subscriber Name	Subscriber Birthdate	Subscriber Social Security #	Relationship to patient

Emergency Contact (Please provide a phone number different from the one listed above)

Name	Emergency Phone Number	Relationship to patient
Name	Emergency Phone Number	Relationship to patient

My permission is given to release any medical information to:

Name	Phone Number	Relationship to patient
Name	Phone Number	Relationship to patient

The Patient/Guarantor is responsible for payment in full of all services rendered by Knoxville Gastrointestinal Specialists, PC. Payment in full is expected at the time services are rendered unless arrangements are made in advance.

Authorization, Assignment, And Responsibility of Account

I hearby authorize Knoxville Gastrointestinal Specialists, PC to release any medical or other information needed to my insurance companies for claims reimbursement. I hearby assign and direct my insurance to pay without further notice from me to the physician. I certify that the information completed by me is correct. I hearby acknowledge and accept responsibility for payment in full of all services rendered to me by Knoxville Gastrointestinal Specialists, PC.

______________________________ ______________________

Patient Signature **Today's Date**

Knoxville Gastrointestinal Specialists
Health Information Questionnaire

Name	Birthdate	Today's Date

Referring Physician	Reason for visit

Pharmacy Name, Address, Phone #

Circle Yes or No if you <u>currently</u> have any of the following:

Heartburn	Yes	No
Difficulty swallowing	Yes	No
Nausea or Vomiting	Yes	No
Abdominal pain	Yes	No
Ulcer history	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Laxative use	Yes	No
Change in stool	Yes	No
Black stool	Yes	No
Blood in stool	Yes	No
Rectal bleeding	Yes	No
Hemorrhoids	Yes	No
Jaundice	Yes	No
Gallbladder surgery	Yes	No
Hepatitis	Yes	No
Prior colon polyps	Yes	No
Aspirin use	Yes	No
Arthritis medication	Yes	No
Blood thinner	Yes	No
Latex allergy	Yes	No

Circle Yes or No if you have any of the following medical problems:

Asthma	Yes	No
Bleeding problems	Yes	No
Cancer	Yes	No
COPD/Emphysema	Yes	No
Home oxygen use	Yes	No
Diabetes	Yes	No
Heart problems	Yes	No
High blood pressure	Yes	No
HIV/AIDS	Yes	No
Kidney problems	Yes	No
Sleep apnea	Yes	No
Stroke	Yes	No
Prior surgery	Yes	No
Prior endoscopy	Yes	No
Prior colonoscopy	Yes	No
COVID-19 vaccine Date of vaccine(s): ________________________________	Yes	No
Hepatitis A or B vaccine Date of vaccine(s): ________________________________	Yes	No
Flu vaccine Date of flu vaccine: ________________________________	Yes	No

List all drug allergies:

List all other medical problems and surgery:

Please continue on reverse side →

List all current medications, prescription and over the counter, or attach medication list:		
Diabetic or weightloss medications?	Yes	No

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:
□ Colitis If so, whom?
□ Colon cancer If so, whom?
□ Cancer If so, whom? Location of cancer:
□ Colon polyps If so, whom?
□ Crohn's disease If so, whom?
□ Celiac disease If so, whom?
□ Heart disease If so, whom?
□ Liver disease If so, whom?
□ Pancreas disease If so, whom?
□ Other:

Circle Yes or No for the following habits and social history:		
Drink coffee	Yes	No
Smoke tobacco	Yes	No
Formerly smoked	Yes	No
Chew tobacco	Yes	No
History of IV drug use	Yes	No
Drink alcohol now	Yes	No
Number of alcoholic drinks each week: _______________		
Your occupation: ___________________________________		
Who lives with you: _________________________________		

Circle Yes or No for the following symptoms:		
Poor appetite	Yes	No
Fevers	Yes	No
Weight loss	Yes	No
Fatigue	Yes	No
Glaucoma	Yes	No
Hearing problems	Yes	No
Dentures	Yes	No
Sleep apnea	Yes	No
Shortness of breath	Yes	No
Cough	Yes	No
Coughing blood	Yes	No
Chest pain	Yes	No
Palpitation	Yes	No
Blood in urine	Yes	No
Urinary leakage	Yes	No
Bowel control issues	Yes	No
Joint pain	Yes	No
Anesthesia trouble	Yes	No
Difficult intubation	Yes	No
Easy bruising	Yes	No
Abnormal lumps	Yes	No
Insomnia	Yes	No
Depression/Anxiety	Yes	No

Please list any other relevant information:

Information provided by patient on these forms (page 1 and 2) were reviewed.

Physicians Initials: __________________________

Privacy Notice

I have reviewed a copy of Knoxville Gastrointestinal Specialist's, P.C. Notice of Privacy Practices. I understand that this Notice describes how my health information may be used or disclosed by KGIS, P.C. and that I should read it carefully. I consent to KGIS, P.C.'s use of protected health information as described in the notice. I am aware that the Notice may be changed at any time. I may obtain a current copy of the Notice by calling (865) 523-6418 or by requesting one in person at the office. This is also available at www.knoxgi.com.

____ _______________________

Signature of Patient or Patient's Representative Date

________(Initial) INSURANCE Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to provide the office with current insurance information. **Please have your insurance card each time you present to the office.** You are responsible for notifying us of any changes in your insurance coverage. If you fail to do so in a timely manner, you will be responsible for the balance. If you are an uninsured patient, payment in full is expected at the time of service.

________(Initial) CO-PAYS/DEDUCTIBLES Co-payments are due at check-in prior to being seen by the provider. You will also be asked to make a payment on any balance you may have from previous services. Unmet deductibles are the patient's responsibility prior to services rendered. Any unpaid balances may be sent to a third-party collection agency upon a 90-day period of no payment. There may be other fees associated with the collection account from the third-party collector.

________(Initial) MISSED APPOINTMENT AGREEMENT Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Effective October 1, 2023, Appointment and Cancellation Policy details:

- Any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with at least 24-hour notice will be considered a no show and may be charged a $25.00 fee.
- If a third no show or cancellation/reschedule without a 24-hour notice should occur, the patient may be discharged from Knoxville Gastrointestinal Specialists.
- Any new patient who fails to show for their initial visit may be rescheduled one time.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit and/or upon receipt of statement, whichever occurs first.
- As a courtesy, we make reminder calls/texts/emails for appointments. Regardless of whether you received the reminder, the above policy will remain in effect.