Reset Form

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PATIENT INFORMATION REGISTRATION FORM

(PLEASE PRINT CLEARLY)

Full Name: _____ DOB: _____Sex:_____

Street Address _____

City:_____ State:_____Zip:_____

Home Phone: _____ Alternate Phone (Cell, etc.)_____

S.S. #: _____ Email:_____

Patient's Employer: _____Employer Phone #:_____

Marital Status:_____ Spouse: _____

Primary Physician: _____Telephone:_____

In case of emergency, contact: _____

Relationship: _____ Telephone: _____

REFERRAL INFORMATION (Please tell us how you were referred to our practice)

Source: _____

PATIENT AUTHORIZATION

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorized payment of medical benefits to the undersigned physician or supplier for service described below.

SIGNED: _____ DATE: _____

NOTE:

Please provide us with your driver's license and insurance card(s) so that we may make photocopies of them.

Please review our Notice of Privacy Policies as required by the Health Insurance Portability and Accountability Act of 1996, HIPAA. If you have any questions, we would be more than happy to answer them for you.

Patient History

Note: This is a confidential record and will remain in your doctor's office. Information contained here will not be given to anyone without your authorization to do so.

Today's Date ____/_____/_____ Date of Last Physical Exam _____/_____/_____
Name _____ Social Security Number _____

Chief Complaint
What is the main reason of your visit today?

_____

Past Medical History

List any significant past illnesses:
_____
_____
_____

List all current medications:
_____
_____
_____

List any prior operations:
_____
_____
_____

Do you have any medication allergies? Yes No
If yes, please list.

_____
_____

Do you have any unusual bleeding? Yes No
If yes, please explain.

_____

Are you taking any Aspirin, ibuprofen, or any other drugs that my cause blood thinning? Yes No
If yes please list.

_____

(OVER)

Review of Systems

Do you now or have you had any problems related to the following systems?
Please Circle **Y**es or **N**o. Provide explanation if necessary.

Constitutional Systems
Fever Y N
Chills Y N
Headache Y N
Other_____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other_____

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other_____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness Y N
Other_____

Endocrine
Excessive thirst Y N
Too Hot/Cold Y N
Tired/sluggish Y N
Other_____

Gastrointestinal
Abdominal pain Y N
Nausea/Vomiting Y N
Indigestion Y N
Heartburn Y N
Other_____

Cardiovascular
Chest pain Y N
Varicose veins Y N
High Blood Press Y N
Other_____

Skin
Rash Y N
Boils Y N
Persistent Y N
Other_____

Musculoskeletal
Joint pain Y N
Neck pain Y N
Back pain Y N
Other_____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other_____

Respiratory
Wheezing Y N
Frequent cough Y N
Short Breath Y N
Other_____

Hematologic
Swollen glands Y N
Blood clotting Y N
Other_____

Psychological
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Are you satisfied with your life? Y N
Other_____

Physician: _____

Date: _____

PATIENTS RIGHTS AND RESPONSIBILITES

(As required by the Health Insurance portability and Accountability Act of 1996, HIPAA)

You, as the patient, have the right to…..

Access to Care**:**
Impartial access to treatment that is medically indicated regardless of color, age, creed, sex or national origin.

Respect and Dignity**:**
Considerate, respectful care at all times and under all circumstances, including reasonable attempts to respect religious and cultural beliefs and practices and to make efforts to accommodate whenever possible.

Privacy and Confidentiality**:**

- Be interviewed, examined and treated in surroundings designed to provide
  reasonable privacy.
- Have your medical record read only by those directly involved in your care, in the monitoring of the quality of that care, or by those designated to you.
- Review your medical record and to have information explained, except when restricted by law.
- Expect information related to your office care will not be released without your permission.
- Expect that discussions related to your care will occur in private and include only those with a specific need to know.

Participate in Treatment Discussions**:**

- Be informed and to participate in decisions concerning your care.
- Be given a clear and understandable explanation of procedures including the reason why a procedure is needed, the risk and benefits, probability of success and possible alternatives.
- Complete an advanced directive to indicate your treatment preferences should you become unable to make your own decisions in the future.
- Refuse treatment to the extent permitted by law.
- Be informed of any research activities that affect your care and to choose voluntarily to participate. Refusal to participate will not compromise care.

Personal Safety**:**

- Expect reasonable safety related office practices and environment.

Information**:**

- Be informed about your illness, possible treatments and likely outcome.
- Know the names and roles of caregivers.
- Know the relationship the physician has with outside parties (such as healthcare providers or insurers) that may influence your treatment and care.

Transfer and Continuity of Care**:**

- Expect that the physician will provide necessary health services to the best of his/her ability. If a transfer of care is recommended, you will be informed of the

benefits and alternatives. You will not be transferred without your consent and until another physician agrees to accept you.

Understanding Charges**:**

- Be billed fairly for only those services provided.
- Request an itemized bill for services rendered.
- Ask questions and receive assistance in understanding charges and payment methods.
- Receive timely notice prior to termination of eligibility for reimbursement by any third party payer for the cost of care.

You as the patient, have the responsibility to…

- Provide caregivers with accurate and complete information about your health and convey understanding of what is expected in regard to your treatment.
- Comply with instructions for your treatment plan. If you believe that you cannot follow through with treatment, you are responsible for telling your physician.
- Meet your financial obligations as promptly as possible.
- Be considerate of the rights of other patients and personnel in the control of noise and the respect of property.

GEORGIA'S PATIENT'S RIGHT TO KNOW ACT OF 2001

Georgia's *Patient Right to Know Act*, passed during the 2001 legislative session of the Georgia General Assemble, requires physicians to post a notice in their waiting rooms advising their patients of certain rights effective April 11, 2001.

- The patient has the right to file a grievance with the Composite State Board of Medical Examiners concerning the physician, his/her office and treatment received. The patient should either call the Board with such a complaint or send a written complaint to the Board.

  Composite State Board of Medical Examiners
  2 Peachtree Street, N.W. 10th Floor
  Atlanta, GA 30303-3456
  (404) 656-3913
- The Board is required to investigate every grievance filed and respond in writing.
- The Board will create physician profiles available to the public. (information such as doctor's education, experience, disciplinary actions, malpractice judgments, or felony convictions.)
- The patient has the right to inquire about the cost of treatment prior to receiving treatment.

I _____have read given a copy, and understand Patient Right to Know Act. Date: _____