



**Notice of Privacy Practices  
Patient Acknowledgement**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights and the practice's duties with respect to my protected health information. The Notice includes:

- A statement this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of other uses and disclosures that are prohibited or materially limited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  1. The rights to complain to this practice and the Secretary of Human Health Services if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint
  2. The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction
  3. The right to received confidential communications of protected health information
  4. The right to inspect and copy protected health information
  5. The right to amend protected health information
  6. The right to receive an accounting of disclosures of protected health information
  7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to patient (if signed by a personal representative of the patient):** \_\_\_\_\_



Account No: \_\_\_\_\_ Date: \_\_\_\_\_

**PERSONAL DEMOGRAPHICS**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: Male  Female  Marital Status: Single  Married  Divorced  Widowed

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Person responsible for charges (if other than patient): \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Contact/Follow up Method: Phone  Email  Text

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Policy Holder Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Effective Date: \_\_\_\_\_

ID/Contract #: \_\_\_\_\_

Group/Plan#: \_\_\_\_\_

**Secondary Insurance**

Policy Holder Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Effective Date: \_\_\_\_\_

ID/Contract #: \_\_\_\_\_

Group/Plan#: \_\_\_\_\_

I authorize treatment for the above patient.

I authorize the release of medical records necessary to process insurance claims.

I am responsible to pay for all services received, regardless of insurance coverage.

I authorize payment of medical benefits directly to Treken Primary Care, Inc.

I authorize the release of correspondence and/or medical records to other medical providers involved in my care.

I have read and understand the financial policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



777 Cleveland Avenue · Suite 604·  
Atlanta, GA 30344

Phone: (404) 305-0004 Fax: (404) 305-0494

**HEALTH QUESTIONNAIRE**

REASON FOR VISIT  
FAMILY HISTORY

IF ANY RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE

1) Epilepsy	11) Bleeds easily
2) Migraines	12) Osteoporosis
3) Mental Illness	13) Arthritis
4) Glaucoma	14) Heart disease
5) Diabetes	15) Stroke
6) Thyroid Disease	16) High blood pressure
7) Hayfever	17) High cholesterol
8) Asthma	18) Alcoholism
9) Anemia	19) Hepatitis
10) Cancer	20) Others, please specify:

HOSPITAL ADMISSIONS  (Not including pregnancies)	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING (include those you buy without prescriptions)	ALLERGIES	VACCINES	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
		Tetanus/Td	_____	Colonoscopy	_____
		Influenza (flu)	_____	RectalExam/PSA	_____
		Pneumonia	_____	Mammogram	_____
		Hepatitis	_____	TB test	_____
		Shingles	_____	Pap smear	_____
		HPV	_____	Bone density	_____

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (☑) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Tremor/hand shaking	<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Hair loss: recent
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Headaches	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Measles	<input type="checkbox"/> Hair loss: progressive
<input type="checkbox"/> Irregular pulse	<input type="checkbox"/> Jaundice/hepatitis	<input type="checkbox"/> Numbness	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Herpes	<input type="checkbox"/> Male: prostate problems
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis/rheumatism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Polio	<input type="checkbox"/> Female: BC pill
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Stroke	<input type="checkbox"/> Bone fracture/joint injury	<input type="checkbox"/> Easily fatigued	<input type="checkbox"/> Mumps	<input type="checkbox"/> Flushing, menopause
<input type="checkbox"/> On exertion	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Fevers
<input type="checkbox"/> Lying flat	<input type="checkbox"/> Constipation	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hives	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chills
<input type="checkbox"/> Leg pain: when walking	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> STDs	<input type="checkbox"/> Nightsweats
<input type="checkbox"/> Mental illness	<input type="checkbox"/> Crohn's/Ulcerative colitis	<input type="checkbox"/> Foot pain	<input type="checkbox"/> Eczema	<input type="checkbox"/> Sleep problems:	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> German measles	<input type="checkbox"/> IBS	<input type="checkbox"/> Rashes	<input type="checkbox"/> Sexual problems	How long: _____	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Loss of appetite: (recent)	<input type="checkbox"/> Bloody or tarry stools	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Depression	How frequent: _____	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Urine infections: frequent	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Alcohol _____ oz/week	<input type="checkbox"/> Urinary frequency
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hernia	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Coffee/tea _____ cups/day	<input type="checkbox"/> Frequent thirst
<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Urination: Incontinence	<input type="checkbox"/> Height loss	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Smoking: _____ cig/day	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Urination: Blood	<input type="checkbox"/> Appetite	<input type="checkbox"/> Scarlet fever	How many years? _____	<input type="checkbox"/> Cough
				Year quit: _____	