1240 EAGLES LANDING PARKWAY • SUITE 100 • STOCKBRIDGE GA 30281
PHONE 770) 506-0100 FAX 770) 507-2597

NEW PATIENT INFORMATION

Print Name: _____ **DOB:** ____/____/____

SSN: ____-___-____ **Gender:** _____ **Age:** _____ **Race:** _____

Marital Status: _____ **Employment Status:** _____

Employer: _____

Employer Address: _____

Email Address: _____

Address: _____ **Home Phone:** _____-_____-_____

_____ **Cell Phone:** _____-_____-_____

_____ **Work Phone:** _____-_____-_____

Emergency Contact: You must list someone for us to contact in case of an emergency.

Name: _____ **Phone Number:** _____-_____-_____

Relationship to Patient: _____

INSURANCE INFORMATION:

Insurance Company: _____ **Policy Number:** _____

Policy Holder Name: _____ **Group Number:** _____

Relationship to Patient:_____ **Policy Holder DOB:** _____-___-_____

Policy Holder's Place of Employment: _____

Past /Present Medical History and Review of Systems

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Chest pain/chest tightness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent urination
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Low back problems
- ☐ Skin disease
- ☐ Blood disorder
- ☐ Venereal disease
- ☐ Impotence or Erectile Dysfunction
- ☐ Congestive Heart Failure
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Persistent Cough
- ☐ TB
- ☐ Hay Fever
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Difficultly urinating
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Gout
- ☐ Numbness/Tingling
- ☐ Atrial Fibrillation
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Unexplained weight loss
- ☐ Hemorrhoids
- ☐ Gall Bladder disease
- ☐ Colitis
- ☐ Hepatitis or Jaundice
- ☐ Thyroid disease
- ☐ Head/Neck radiation
- ☐ Headaches
- ☐ Kidney Disease
- ☐ Kidney stones
- ☐ Anemia
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Bleeding due to a clotting disorder
- ☐ Other

Pain? ❑Yes ❑No

If yes, please specify the location & intensity.

_____

_____

_____

Notes to Physician (such as your reason for the visit today)

_____

_____

_____

Allergies (to Medications, X-Ray Dyes or other Substances)

(If so, please list the name of the substance & type of reaction.)

_____ _____ _____

_____ _____ _____

Gynecologic & Obstetric History (Females only)

Age at onset of periods_____ Frequency _____ Length of Period _____

Number of Pregnancies_____ Number of Births _____ Miscarriages _____

Prolonged or abnormal bleeding? ____Yes ____No Explain:_____

Leakage of urine? ____Yes ____No Explain:_____

Pelvic pain? ____Yes ____No Explain:_____

Abnormal discharge? ____Yes ____No Explain:_____

History of abnormal pap smear? ____Yes ____No Explain:_____

CURRENT TOBACCO SMOKER _____Yes _____No
If YES, Number of years you have been smoking? _____How many packs per day / week? ____

FORMER TOBACCO SMOKER _____Yes _____No
If YES, Number of years that you smoked? _____ How many packs per day / week? _____

LAST MAMMOGRAM: _____/_____/_____ ❑Never
LAST PAP SMEAR: _____/_____/_____ ❑Never
HYSTERECTOMY: _____/_____/_____ ❑Never
_____FULL _____PARTIAL

LAST BONE
DENSITY STUDY: _____/_____/_____ ❑Never

LAST
COLONOSCOPY: _____/_____/_____ ❑Never

LAST DILATED
EYE EXAM: _____/_____/_____ ❑Never

IMMUNIZATIONS:
LAST TETANUS: _____/_____/_____
LAST PNEUMOVAX: _____/_____/_____
LAST INFLUENZA
VACCINE: _____/_____/_____
LAST ZOSTAVAX
(SHINGLES): _____/_____/_____

LIST ANY & ALL SURGICAL PROCEDURES YOU HAVE EVER HAD:
_____
_____
_____

LIST ANY & ALL HOSPITALIZATIONS YOU HAVE EVER HAD:
_____
_____
_____

FAMILY HISTORY:
_____
_____
_____
_____
_____

MEDICATION LIST

You must list any current prescribed medications, anything that you need refilled, any vitamins and/or over the counter medications.

Medication Name	Dosage	Directions

PHARMACY INFO

(The pharmacy listed here is where all medications will be sent unless the patient specifies otherwise.)

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy address: _____

_____

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HIPPA - RELEASE OF INFORMATION

Patient Name: _____Date of Birth:_____Today's Date:_____

I, _____, authorize Med South Primary Care to release my information (including but not limited to chart records, lab results, account/balance information, medications, appointment information, etc.) to the specified people listed below (print names only):

- ☐ Spouse/Partner _____
- ☐ Parent _____
- ☐ Child _____
- ☐ Other (Please specify relationship to the patient)

_____

_____

Please keep in mind that if the person is not listed on this form, we are not able to give information over the phone or in person regarding appointment dates/times, account balances, labs/imaging results, new medications, medication changes, anything discussed during office visits, or take messages for the physicians.

This agreement will remain in effect until further notice, which must be submitted by the patient in writing or by completing a new release form.

_____ _____
Patient Name – Print Patient Signature

_____ _____
Witness Signature (Med South Employee) Today's Date

WELCOME TO MED SOUTH PRIMARY CARE!

Please take a minute to review our payment policies. Our receptionist or office manager will be happy to answer any questions that you have. Below you will find a list of payment policies set forth by our billing service.

PAYMENT POLICIES:

All charges that you incur at our office are your personal responsibility to pay. You may pay for your charges in full at each visit or, AS A COURTESY, Med-South, will file it to your insurance for you.

We require you to pay any unmet deductible at each visit. All co-insurance or co-pays must be paid at each visit.

All payments to Med-South are considered deposits against your outstanding balance. No refunds will be made as long as there is an outstanding balance on your account. Any money over paid will be considered a credit to your account and can be applied to your next visit.

Med-South will notify you of any charges that your insurance company declines to pay and ask that you make payments to Med-South in a timely manner.

Med-South will use their best efforts to obtain payment from your insurance company. However, any charges that remain unpaid 60 days after billing become your personal responsibility to pay. Any fees left unpaid (90 days after billing the patient) will be turned over to our collection's agency, CBA of Macon.

Any bills that you receive from the lab are not handled through Med South. Our phlebotomist draws blood that gets sent to either Quest or LabCorp, any fees owed to the lab would be paid directly to them. Every insurance company has a preferred lab that they use. We do our best to assist patients with lab requisition orders; however it is solely the patient's responsibility to know which lab their blood work should be sent to. You can contact your insurance company to find out which lab is preferred for your plan. Any questions you have about a lab bill will have to be handled through the lab.

Your insurance company must allow you to have reimbursement payments sent directly to Med-South. If your insurance company does not allow this we require that you pay for all treatment at the time of your visit.

I HAVE READ AND UNDERSTAND MEDSOUTH'S PAYMENT POLICIES.

_____ _____

Signature Date

APPOINTMENT POLICIES

- APPOINTMENTS are called back by the appointment time, not the arrival time. If others are being called back before you but arrived after you, please keep in mind that their appointment time may be before yours on our schedule.
- WORK IN appointments will be seen after the scheduled patients, so you may experience a longer wait time than usual if we are working you in. If you are sick, please call the office as soon as possible so that we can give you our next available time slot.
- NO SHOW patients are responsible for a $30 NO-SHOW fee.
- CANCELLATIONS need to be made 24 hours before your appointment time, or there will be a $30 NON-CANCELLED fee.
- INSURANCE must be updated upon each visit so that we can properly file the claims. It is the patient's responsibility to notify us of any change of insurance, secondary insurance or supplemental insurance.
- **SCHEDULED PATIENTS are the only ones allowed in the room with the physician. We do make exceptions for minors, elderly, and handicap needing assistance.**

PRESCRIPTION POLICIES

- REFILLS will not be authorized after hours.
- NARCOTICS are not called in. The physician will make the decision of prescribing them based on medical records, MRI reports, x-rays, etc. You will be asked to come in for appointments once a month with a drug screen test performed in order to receive refills.

WAITING ROOM POLICIES

- CELL PHONES are asked to please be silenced while in the lobby and while in the exam room with the physician.
- FOOD/DRINKS are not allowed in the office. No exceptions.

OTHER POLICIES

- FORMS completed or LETTERS written by the physician have a $25 fee.
- REFERRALS require a 72 hour notice before the scheduled appointment. Insurances vary on turn-around time and some referrals do not get approved right away. We cannot complete them same day.

Signature **Date**

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION

I hereby give my consent for Med-South Primary Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Med-South Primary Care's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy practices prior to signing this consent. Med-South Primary Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Med-South Primary Care at 1240 Eagles Landing Parkway, Suite 100, Stockbridge GA 30281.

With this consent, Med-South Primary Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Med-South Primary Care may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal & Confidential.

With this consent, Med-South Primary Care may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, statements, and lab results. I have the right to request that Med-South restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Med-South Primary Care's use and disclosure of my PHY to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request. **If I do not sign this consent, or later revoke it, Med-South Primary Care may decline to provide treatment to me.**

_____ _____

Signature Date

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PHONE 770)506-0100 FAX 770)507-2597

NOTICE OF PRIVACY PRACTICES

Med South Primary Care requires the following information from the patient to be able to properly file health insurance claims in a timely manner:

-Full Name
-Date of Birth
-Social Security Number
-Mailing Address
-Policy Holder's full name, DOB, mailing address

Med South Primary Care uses the above information to file insurance claims. This information is confidential and is not used for any other reason than to file insurance claims. This information is used by Med South Primary Care employees to assist the patient on the phone with questions regarding claims, to help locate charts or to assist outsourced entities with filing insurance correctly. For example, in the event that the outsourced entity if given partial or incorrect information, the entity may call our office and request correct information to properly re-file. Examples of outsourced entities are imaging facilities or specialist offices who we have referred the patient to, in-house lab such as Quest Diagnostics or LabCorp, etc.

NOTICE OF PATIENT'S RIGHTS AND RESPONSIBILITIES

The patient has the right to:

-receive humane care and treatment with respect and consideration,
-privacy and confidentiality when seeking or receiving care except in life threatening conditions or situations,
-confidentiality of health records within parameters stated above,
-be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access
to medical care and treatment,
-receiving accurate information concerning diagnosis, treatment, risks and prognosis of an illness.
-ask about reasonable alternatives to care,
-participate actively in decisions regarding your healthcare & treatment.

The patient has the responsibility to:

-provide complete information about your health/illness/problem and to enable proper evaluation and treatment, update all information as soon as changes occur (such as address, phone number, insurance),
-ask questions so that an understanding of the condition is ensued,
-show respect to health care personnel and other patients,
-reschedule/cancel an appointment so that another person may be given that time slot,
-pay balances or health care claims in a timely manner, and also have all balances paid prior to your next appointment,
-use prescriptions of medical devices for yourself only,
-inform the providers if your condition worsens or an unexpected reaction occurs.

If the patient has any sort of question or complaint, the patient can submit it in writing to:

Med South Primary Care
Attn: Office Manager
1240 Eagles Landing Parkway, Suite 100
Stockbridge GA 30281

_____ _____
Patient Signature Date

Please note that this notice of Privacy Practices & Patients Rights and Responsibilities is subject to change at any time.

ALLERGY ASSESSMENT FORM

PATIENT NAME : _____ DATE:_____

INSURANCE : _____PHONE NUMBER:_____

1. Do you occasionally have itchy watery eyes, sniffles, and/or runny nose? ___Yes___No
2. Do you have any food allergies? ___Yes ___No
3. Have you ever had an allergic reaction before? ___ Yes ___No
4. Have you ever had allergy shots? ___Yes ___No
5. Do you have asthma? ___Yes ___No
6. Have you taken any medications for allergies? ___Yes ___No
7. Are you currently taking any Beta Blockers? [Heart Medication] ___Yes ___No
8. Are you pregnant? ___Yes ___No
9. Do you occasionally have itching and do not know the cause? ___Yes ___No
10. Have you taken any antihistamines? ___Yes ___No
11. BMI over 25? ___Yes ___No

If you answered YES to any of the above questions, you may be at risk for allergies.
PLEASE consult with your physician regarding allergy testing.

_____
Patients Signature

_____
Physician Signature

FOR OFFICE USE ONLY

APPTOINTMENT: _____/_____/_____ TIME: ____:_____ AM PM

CALL ATTEMPTS: _____/_____/_____ TIME: ____:_____ AM PM
_____/_____/_____ TIME: ____:_____ AM PM

_____PATIENT DECLINED: WHY? _____

PHARMACY INFO

(The pharmacy listed here is where all medications will be sent unless the patient specifies otherwise.)

Local Pharmacy Name: _____
Pharmacy address: _____
Mail Order Pharmacy: _____
(if you use a mail order pharmacy, you must also list a local pharmacy as a back-up)

MENTAL HEALTH ASSESSMENT

Over the past 2-3 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half**	**Nearly Every Day**
1. Feeling down, depressed or hopeless	[ ]	[ ]	[ ]	[ ]
2. Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
3. Trouble falling asleep, staying asleep or sleeping too much?	[ ]	[ ]	[ ]	[ ]
4. Poor appetite or overeating	[ ]	[ ]	[ ]	[ ]
5. Feeling tired or having little energy?	[ ]	[ ]	[ ]	[ ]
6. Feeling bad about yourself – or that you're a failure – or that you've let yourself or your family down	[ ]	[ ]	[ ]	[ ]
7. Trouble concentrating on things, such as reading or watching tv	[ ]	[ ]	[ ]	[ ]
8. Moving or speaking so slowly that others have noticed. Or the opposite - being so fidgety or restless – moving more than usual	[ ]	[ ]	[ ]	[ ]
9. Thoughts that you would be better off dead or thoughts of hurting yourself in any way	[ ]	[ ]	[ ]	[ ]

10. In the past year, have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely Difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

13. Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

NAME: _____ **DOB:**_____ **TODAY'S DATE:**_____

Allergies: _____
Any changes in medications? _____
Recent injuries? _____
Recent surgeries? _____
Last eye exam? _____
Date & location of last flu shot? _____
Date & location of last tetanus shot? _____
Date & location of last Pneumovax? _____
Date & location of last Prevnar vaccine? _____
Date & location of last Shingles vaccine? _____
Are you diabetic? [ ] Yes [ ] No (if yes, you may be asked to remove your shoes for a diabetic foot exam)

Rate your overall well-being. [ ] Great [ ] Good [ ] Fair [ ] Poor [ ] Bad
Rate your health. [ ] Great [ ] Good [ ] Fair [ ] Poor [ ] Bad
Rate your sleep quality. [ ] Great [ ] Good [ ] Fair [ ] Poor [ ] Bad
How many times do you wake up during the night? _____
How many hours of sleep do you get per night? _____
Have you ever been told that you snore? [ ] Yes [ ] No
How safe do you feel in your own home? [ ] Very [ ] Not Very [ ] Not at all
How safe do you feel around your partner? [ ] Very [ ] Not Very [ ] Not at all
Are you being abused in any way? [ ] Yes [ ] No [ ] Ask me in private

How often do you smoke tobacco? [ ] Never [ ] Occasionally [ ] Often [ ] Daily [ ] Used to
How often do you chew tobacco? [ ] Never [ ] Occasionally [ ] Often [ ] Daily [ ] Used to
When did the tobacco use start? _____
How many cigarettes do you smoke per day? _____
How often do you drink alcohol? [ ] Never [ ] Occasionally [ ] Often [ ] Daily [ ] Used to
How often do you binge drink (5+ drinks in 1 hour)? [ ] Never [ ] Occasionally [ ] Often [ ] Daily [ ] Used to
How many alcoholic drinks do you have per week?_____
Have you ever been treated for alcoholism? [ ] Yes [ ] No
Have you ever blacked out from drugs/alcohol? [ ] Yes [ ] No
How often do you use recreational drugs? [ ] Never [ ] Occasionally [ ] Often [ ] Daily [ ] Used to
If so, which drugs have you used? _____
Have you ever abused prescription drugs? [ ] Yes [ ] No
If so, which prescription drugs?_____
Would you like to discuss options to quit smoking? [ ] Yes [ ] No

Males:	**Females:**
Date of last PSA? _____ (prostate screening lab work?) Last colonoscopy? _____	Method of birth control? _____ Start date of last cycle? _____ Date of last pap smear?_____ Date of last mammogram? _____ Date of last colonoscopy? _____ Date of last bone density? _____