# DeKalb Medical Physicians Group

## PATIENT INFORMATION - PLEASE PRINT

| NAME (Last, First Middle) | | SSN# | BIRTHDATE | SEX |
|---|---|---|---|---|
| | | | | |

| LOCAL ADDRESS | APT# | CITY, STATE ZIP |
|---|---|---|
| | | |

| HOME PHONE | CELL PHONE | PREFERRED PHONE | EMAIL ADDRESS |
|---|---|---|---|
| | | | |

| EMERGENCY CONTACT NAME | TELEPHONE NUMBER | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

| PRIMARY EMPLOYER | WORK PHONE |
|---|---|
| | |

| ADDRESS | CITY, STATE ZIP |
|---|---|
| | |

## RESPONSIBLE PARTY INFORMATION (If Different than above)

| NAME (Last, First Middle) | | SSN# | BIRTHDATE | SEX |
|---|---|---|---|---|
| | | | | |

| LOCAL ADDRESS | CITY, STATE ZIP | SECONDARY /BILLING ADDRESS (If Applicable) |
|---|---|---|
| | | |

| HOME PHONE | CELL PHONE | PREFERRED PHONE | CITY, STATE ZIP |
|---|---|---|---|
| | | | |

| EMPLOYER | RELATIONSHIP TO PATIENT |
|---|---|
| | |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | | POLICY# | |
|---|---|---|---|
| | | | |
| NAME OF INSURED | | GROUP# | |
| | | | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT | |
| | | $ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE | |
| | | $ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |
| | | | |

## SECONDARY INSURANCE (If Applicable)

| NAME OF INSURANCE COMPANY | | POLICY# | |
|---|---|---|---|
| | | | |
| NAME OF INSURED | | GROUP# | |
| | | | |
| ADDRESS OF INSURANCE COMPANY | | COPAY AMT | |
| | | $ | |
| CITY, STATE ZIP | PHONE | DEDUCTIBLE | |
| | | $ | |
| RELATIONSHIP TO PATIENT | | EFFECTIVE DATE | EXPIRATION DATE |
| | | | |

I authorize the release of any medical or other information necessary to process this claim, including information related to AIDS, Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

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**Patient Medical History Form**

Name:_____ Age:_____ Date of Birth:_____
Language(s) spoken:_____ Occupation:_____
Religious Preference:_____ Highest Level of Education Completed:_____
Marital Status: _____Single _____Married _____Partnered _____Divorced _____Widowed

**Allergies (Medications, X-ray Dyes, Other Substances):**
*Please list and describe type of reaction:*

_____
_____
_____

**Past Medical History/Review of Systems:**
*Please check if you have had problems or been diagnosed with any of the following:*

| | | |
|---|---|---|
| _____High Blood Pressure | _____Abdominal Discomfort | _____Kidney Stones |
| _____Diabetes | _____Indigestion/Heartburn | _____Difficulty Urinating |
| _____Cancer | _____Nausea | _____Arthritis* |
| _____Heart Disease | _____Vomiting | _____Low Back Pain/Problems* |
| _____Chest Pain/Discomfort | _____Constipation | _____Skin Diseases |
| _____Shortness of Breath | _____Diarrhea | _____Blood Disorder |
| _____Swollen Ankles | _____Blood in Stool | _____Venereal Disease |
| _____Palpitations/Racing Heart | _____Ulcer | _____Anxiety |
| _____Lightheadedness | _____Change in Bowel Habits | _____Anemia |
| _____Frequent Urination | _____Unexplained Weight Change | _____Depression |
| _____Rheumatic Fever | _____Hemorrhoids | _____Alcohol Abuse |
| _____Asthma | _____Gall Bladder Disease | _____Drug Abuse |
| _____Bronchitis | _____Colitis | _____Gout* |
| _____Pneumonia | _____Hepatitis/Jaundice | _____Difficulty with Movement* |
| _____Persistent Cough | _____Thyroid Disease | _____Difficulty Seeing* |
| _____Tuberculosis | _____Muscle Pain* | _____Difficulty Hearing* |
| _____Hay Fever | _____Headache | _____Kidney Disease |
| _____Other:_____ | *Indicates potential for functional difficulty | |

**Please list all current medications you take (including prescription, over the counter, vitamins, herbs, etc.):**

_____
_____
_____
_____

**Please list any surgery or hospitalization(s) which you have had and include the date(s):**

_____
_____
_____

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**Name** _____ **DOB** _____ **Date** _____

**Nutritional Status:**

Appetite: _____Good _____Fair _____Poor

Are you on any special diet? _____Yes _____No If yes, what type?_____

Do you currently use herbs or nutritional supplements in your diet? _____Yes _____No

Have you had any unintentional weight loss/gain in the last 6 months? _____Yes _____No Pounds:_____

Do you wear dentures? _____Yes _____No

*Please check if you have ever had any:*

_____Difficulty swallowing

_____Difficulty chewing

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**Gynecologic/Obstetric History:**

Age onset of menstrual period:_____ Length of menstrual period:_____ Frequency:_____

Pregnancies_____ Births_____ Miscarriages_____ Abortions_____

Age at first pregnancy:_____ Are you pregnant at this time? _____Yes _____No

Date of last pap smear:_____ Have you ever had an abnormal pap smear? _____Yes _____No

*If yes, please describe finding:*_____

Date of last mammogram:_____ Have you ever had an abnormal mammogram? _____Yes _____No

*If yes, please describe finding:*_____

Do you perform self breast exam? _____Yes _____No If yes, how often? _____

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**Immunization/Preventive Screening History:**

*Have you received any of the following:*

| | | | | |
|---|---|---|---|---|
| Pneumovax | _____Yes | _____No | _____Don't know | Date_____ |
| Hepatitis B | _____Yes | _____No | _____Don't know | Date_____ |
| Hepatitis A | _____Yes | _____No | _____Don't know | Date_____ |
| Influenza | _____Yes | _____No | _____Don't know | Date_____ |
| Tetanus | _____Yes | _____No | _____Don't know | Date_____ |
| Measles, Mumps, Rubella | _____Yes | _____No | _____Don't know | Date_____ |
| Polio | _____Yes | _____No | _____Don't know | Date_____ |

Date of last Cholesterol? _____ Date of last stool check for blood? _____

Sigmoidoscopy, if over age 50? _____ Date of last prostate exam, if over age 50? _____

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**Family History:** *Please check and describe if any member of your family (including parents, siblings and grandparents) ever had:*

_____Cancer _____ _____Hypertension _____

_____Heart Disease _____ _____Diabetes _____

_____Stroke _____ _____Mental Illness _____

_____Addiction _____ _____Glaucoma _____

_____Blood Disorder _____ _____Other _____

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**Prevention:**

Do you smoke? Yes ☐ No ☐ Packs per day_____ Do you drink alcohol? Yes ☐ No ☐ Amount/week_____

Do you wear a seatbelt? Yes ☐ No ☐

Do you wear a bicycle helmet? Yes ☐ No ☐

Do you drink Caffeine? Yes ☐ No ☐

Do you use drugs (including Marijuana, Cocaine, etc...)? Yes ☐ No ☐ Describe:_____

Do you engage in activity which places you at risk for acquiring AIDS? Yes ☐ No ☐ Describe:_____

Do you wish to be tested for AIDS? Yes ☐ No ☐

Do you work with any occupational hazards such as chemicals, paints, asbestos, etc...? Yes ☐ No ☐

Are you in a relationship in which you have been physically hurt? Yes ☐ No ☐

Do you ever feel afraid of your partner? Yes ☐ No ☐

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Is there a gun in your home? Yes ☐ No ☐ If yes, is it out of the reach of children and unloaded?_____

Do you have a Living Will? Yes ☐ No ☐

Would you like information on a Living Will? Yes ☐ No ☐

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# PATIENT CONSENT FORM

## CONSENT FOR ROUTINE PROCEDURES & TREATMENTS

We are required by law to obtain a consent to treat and disclose "all material risks and alternative treatments." I understand that it is not possible to list every material risk for every Procedure or Treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the Procedures or Treatments.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as injections (shots), intravenous lines, or intravenous injections. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis of limb or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- **If I have any questions or concerns regarding these Treatments or Procedures, I will ask my physician to provide me with additional information**.

Signature of Patient (or authorized person to sign): _____

Printed Name of Patient: _____

Reason Patient Unable to Sign (if applicable): _____

Date Signed: _____

[redacted]

**Acknowledgement of Receipt of Notices of Privacy Practices (HIPAA):** I acknowledge that I have received the notice of Privacy Practices.

_____ _____

Signature Date

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**Patient Approval Form for Physician Assistant**: If this practice has a certified Mid-Level Provider available to treat patients for the level of care, which have been approved by the Georgia State Board of Medical Examiners, your signature on this form conveys that you are in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

_____

Patient Signature

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# Notice of Privacy Practices in the Use and Disclosure of Personal Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

## Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and/or receive a copy your health record (a fee may be applied)
- request an amendment or correction to your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

## Our Responsibilities

The organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice.

## For More Information or to Report a Problem

If you have a question and would like additional information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Please submit your question or complaint in writing and mail to: Privacy Officer, DeKalb Medical, 2701 North Decatur Road, Decatur, Georgia 30033.

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## Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

We will use your health information for payment.
A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

- *Quality Improvement*: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in you health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- *Business Associates*: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- *Directory*: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to people who ask for you by name.
- *Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location and general condition.
- *Communication with family*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- *Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- *Funeral Directors*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- *Organ procurement organizations*: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- *Marketing*: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fund raising*: We may contact you as part of a fund-raising effort.
- *Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution*: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement*: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- *Federal oversight agency*: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.