Keith Family Medicine
1025 East Freeway Drive Southeast, Conyers, GA. 30094
Phone (770) 929-1115

Patient Registration Form

Patient Information	**Patient Information:**		
	Last Name:	First Name:	M.I.:
	Mailing Address:		
	City/State/Zip:		
	Home Phone:	Cell Phone:	
	Work Phone:	Email:	
	Date of Birth:	Gender: ☐ Male ☐ Female ☐ Transgender	
	Social Security #:	Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Other _____	
	Employment:	Employer Name:	
	Emergency Contact Name	Emergency Contact Phone #:	Relationship to Patient:
Additional Information	**Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian brining the patient in will be listed as the guarantor:**		
	Last Name:	First Name:	
	Date of Birth:	Social Security #:	Phone:
	Address of the Person Responsible:		
	City/State/Zip:		Relationship to Patient:
	Pharmacy Information		
	Name:	Phone:	Fax:
	Address:		
	City/State/Zip:		
Insurance Information	**Primary Medical Insurance**	**Secondary Medical Insurance**	
	Ins. Co. Name:	Ins. Co. Name:	
	Policy Holder Name:	Policy Holder Name:	
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:	
	Policy Holder's Social Security #:	Policy Holder's Social Security #:	
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:	

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

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Name: _____ Date of Birth:_____/_____/_____
Last First

Current Medications

(Include all Prescriptions, Supplements, Over the Counter and Herbal Medications)

	Name	Dose	Frequency	Diagnosis (asthma, depression…etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Allergies / Intolerances

Do you have allergies/intolerances to medications or other substance? ☐ No ☐Yes, please list:	1		3	
	2		4	

Past Medical Problems

(Diabetes, hypertension, Thyroid… etc)

	Problem	Date/Age diagnosed		Problem	Date/Age diagnosed
1			5		
2			6		
3			7		
4			8		

Past Surgeries

	Surgery	Date		Surgery	Date
1			3		
2			4		

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Family History

(Please indicate if they have or ever had any of the following medical conditions)

Father: ☐ Alive Age or DOB_____ ☐ Deceased Cause and age of death. _____	☐ High Blood Pressure ☐ Elevated Cholesterol Levels ☐ Diabetes, ☐ Type 2 ☐ Type 1 ☐ Coronary Heart Disease, Age Diagnosed _____ ☐ Stroke, Age Diagnosed _____ ☐ Prostate Cancer, Age Diagnosed _____ ☐ Colon Cancer, Age Diagnosed _____ ☐ Other, _____
Mother: ☐ Alive Age or DOB_____ ☐ Deceased Cause and age of death. _____	☐ High Blood Pressure ☐ Elevated Cholesterol Levels ☐ Diabetes, ☐ Type 2 ☐ Type 1 ☐ Coronary Heart Disease, Age Diagnosed _____ ☐ Stroke, Age Diagnosed _____ ☐ Colon Cancer, Age Diagnosed _____ ☐ Breast Cancer, Age Diagnosed _____ ☐ Ovarian Cancer, Age Diagnosed _____ ☐ Other, _____
Siblings: Number of Brothers _____ Sisters _____	☐ High Blood Pressure ☐ Elevated Cholesterol Levels ☐ Diabetes, ☐ Type 2 ☐ Type 1 ☐ Coronary Heart Disease, Age Diagnosed _____ ☐ Stroke, Age Diagnosed _____ ☐ Colon Cancer, Age Diagnosed _____ ☐ Breast Cancer, Age Diagnosed _____ ☐ Ovarian Cancer, Age Diagnosed _____ ☐ Prostate Cancer, Age Diagnosed _____ ☐ Other, _____
Children: Number of Sons _____ Daughters_____	☐ _____ ☐ _____ ☐ _____

Social History

Smoking:
Current Smoker ☐ No ☐ Yes Pack per Day _____For How Many Years_____
Previous Smoker ☐ No ☐ Yes Pack per Day _____For How Many Years_____ Quit Date_____

Alcohol: ☐ No ☐ Social ☐ Yes How much and how often, Type_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Engaged

Occupation:

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Review of Systems

Are you currently or regularly experiencing any of the following signs and symptoms (please check all that apply)

Constitutional

☐ Weight loss or gain
☐ Difficulty falling asleep
☐ Unrefreshed feeling after sleeping
☐ Chronic fatigue

Skin

☐ New skin rashes or moles
☐ Changes to existing skin lesions

Eyes

☐ Diminished or blurred vision
☐ Wear glasses or contact lenses
☐ Last Eye Exam_____

Ears, Nose, Mouth and Throat

☐ Difficulty hearing
☐ Feeling of food stuck in throat or chest
☐ Last Dental Exam _____

Allergic/ Immunologic

☐ Frequently suffer from allergic symptoms (such as itchy eyes, runny nose or sneezing)
☐ Animal or food allergies

Hematologic/Lymphatic

☐ Swollen glands or lymph nodes
☐ Easy bruising

Endocrine

☐ Excessive thirst
☐ Excessive urination
☐ Heat or cold intolerance
☐ Diminished sexual drive

Cardiovascular

☐ Chest pain or tightness (angina)
☐ Skipping heart beat (palpitation)
☐ Trouble breathing when lying flat
☐ Leg pain/cramps when walking
☐ Swelling in legs

Respiratory

☐ Shortness of breath
☐ Persistent cough
☐ Coughing up blood
☐ Wheezing

Gastrointestinal

☐ Heartburn or sour taste in mouth
☐ Constipation
☐ Chronic diarrhea
☐ Changes in bowel habits
☐ Blood in stool

Genitourinary

☐ Blood in urine
☐ Urinary incontinence (leakage)

Men only

☐ Difficulty with erection
☐ Pain or mass in testicles
☐ Weak urine stream

Female only

☐ Heavy/irregular menstrual bleeding
☐ Pain during or following intercourse
☐ Lumps in breast or nipple discharge
☐ Hot flashes
☐ Menopause, Age_____
☐ Post-menopausal vaginal bleeding

Musculoskeletal

☐ Joint pain
☐ Joint swelling or redness
☐ Joint stiffness

Neurological

☐ Tingling
☐ Tremors

Psychiatric

☐ Depression/ sadness
☐ Feel like hurting someone or self
☐ Anxiety

Preventive Medicine

Colonoscopy: Date _____Result_____

Women: Last: Pap smear: _____ /_____ Breast Exam: _____ /_____ Mammogram: _____ /_____

Men: Last: Rectal/Prostate exam: _____ /_____ Testicular exam: _____ /_____ PSA: _____ /_____

Immunization History

Flu: ☐ No ☐ Yes Date_____ /_____ **Pneumonia:** ☐ No ☐ Yes Date_____ /_____

Tetanus: ☐ No ☐ Yes Date_____ /_____ **Hepatitis B vaccine:** ☐ No ☐ Yes Date_____ /_____

Gardasil: ☐ No ☐ Yes Date_____ /_____ **Zoster/Shingles:** ☐ No ☐ Yes Date_____ /_____

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth:_____/_____/_____
Last First

Release of Information
☐ I, authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be release to: ☐ Spouse: _____ ☐ Child(ren): _____ ☐ Other: _____ ☐ Information is not to be released to anyone. This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages
Please call: ☐my home: _____ ☐my work: _____ ☐my cell: _____ If unable to reach me: ☐you may leave a detailed message. ☐please leave a message asking me to return your call. ☐ other:_____ The best time to reach me is (*day*) _____ between (*time*) _____.

Signature (*patient/ legal representative*): _____ Date:_____

Relationship to patient *(if applicable):* _____

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Consent Form to Release/Receive Medical Records

Authorization for Release of Information

I, _____, DOB:_____

SSN:_____ Phone: _____

Address: _____

City/State/Zip: _____

do hereby give my consent and authorize _____ to release unto:

Nabil Keith M.D. LLC, 6002 Highway 53 East, Suite 100, Dawsonville, Georgia, 30534.

Medical Information contained in the medical record for the treatment dates: _____

The following information is requested for release of information:

☐ H&P ☐ Consultations ☐ Pathology reports

☐ Imaging/ X-rays ☐ Lab ☐ Office notes

☐ Entire medical record ☐ Other_____

This information may include, but is not limited to, treatment related to psychiatric or psychological, drug and/or alcohol, or Acquired Immune Deficiency Syndrome/HIV.
I understand that this information is to be disclosed for the following purpose and that purpose only: continuity of care.

I understand that this consent is subject to revocation by me at any time, and unless an earlier date is specified, the consent will automatically expire in 90 days after the date below. I also understand that this information may be bound by the Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records. Re-disclosure of this information to any other party other than the one listed is prohibited without any additional written consent on my part.

Signature (patient/ legal representative): _____ Date:_____

Relationship to patient *(if applicable):* _____

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HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACESS TO THIS INFORMATION.

INTRODUCTION

Nabil Keith M.D. is required by law to maintain the privacy of "protected health information". "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the healthcare you received, or payment for your healthcare.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected information for the purposes of treatment, payment and healthcare operations. For each category, we will explain what we mean and give some examples. However, not every use or disclosure will be listed.

Treatment means the provision, coordination or management of your healthcare, including consultations between healthcare providers regarding your care and referrals for healthcare from one healthcare provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

Payment means activities we undertake to obtain reimbursement for the healthcare provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide to your health plan information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill your health plan for services rendered to you, we can provide them with the information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to treatment and payments, such as quality assurance activities, case management, receiving and responding to patient complaints, physical reviews, compliance programs, audits, business planning, development management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effectives. In addition, we may remove information that identifies you from your health information so that others can use this de-identification information to study health care delivery without learning who you are.

Signature (patient/ legal representative): _____ Date:_____

Relationship to patient *(if applicable):* _____