Brookstone Internal Medicine

Dr. Samantha Boroughs, MD
400 Brookstone Centre Parkway, Suite 200
Columbus, GA 31904

REGISTRATION FORM

(Please Print)

Today's date: ________________

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.: E-Mail Address:	Home phone no.: ( ) Cell Phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Last Primary Care Physician:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient signature *Date*

Brookstone Internal Medicine

Dr. Samantha Boroughs, MD
400 Brookstone Centre Parkway, Suite 200
Columbus, GA 31904
Phone: 706-507-3332 Fax: 706-507-3359

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

Previous Name: ____________________ Social Security #: ____________________

name of prior physicians → I request and authorize ____ to release healthcare information of the patient named above to:

Name: Brookstone Internal Medicine, Dr. Samantha Boroughs

Address: 400 Brookstone Centre Parkway, Suite 200

City: Columbus State: GA Zip Code: 31904

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____________________ Date Signed: ____________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Patient consent form

Brookstone Internal Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Brookstone Internal Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by Brookstone Internal Medicine describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I have been given a copy of the Privacy Practices to review at my initial office visit. Brookstone Internal Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jan Underdown, office manager, 400 Brookstone Ctr Pkwy, Ste 200, Columbus, GA, 31904.

With this consent, Brookstone Internal Medicine 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 any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Brookstone Internal Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Brookstone Internal Medicine may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Brookstone Internal Medicine restrict how it uses or discloses my PHI to carry out TPO. 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 allow Brookstone Internal Medicine to use and disclose my PHI 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 consent. If I do not sign this consent, or later revoke it, Brookstone Internal Medicine may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

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BROOKSTONE INTERNAL MEDICINE

Patient Health History

Name:________________________ Age:_____ DOB:__________ Date: __________
Occupation:____________________ Education:_____High School _____College Graduate

Personal History:

Illnesses:
Have you ever had: (please circle Y for yes or N for no)

High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Heart Disease	Y	N
Heart Attacks	Y	N
Blood Clots	Y	N
Phlebitis	Y	N
Stroke	Y	N
Diabetes	Y	N
Gout	Y	N
Sinusitis	Y	N
Asthma	Y	N
Emphysema	Y	N
Bronchitis	Y	N
Stomach Ulcer	Y	N
Duodenal Ulcer	Y	N
Colitis	Y	N
Gall Bladder Disease	Y	N
Kidney Stones	Y	N
Kidney Infection	Y	N
Bladder Infection	Y	N
Cirrhosis	Y	N
Tuberculosis	Y	N
Cancer	Y	N
Type:______________________		
Goiter	Y	N
Epilepsy	Y	N
Nervous Breakdown	Y	N
Gonorrhea	Y	N
Syphilis	Y	N
Polio	Y	N
Anemia	Y	N
Mumps	Y	N
Rheumatic Fever	Y	N
German Measles	Y	N
Chicken Pox	Y	N
Any Other Disease:____________		

Injuries:

Concussion or Head Injury	Y	N
Car Accident Injury	Y	N
Ever Been Knocked Unconscious?	Y	N

Allergies: are you allergic to:

Penicillin	Y	N
Aspirin	Y	N
Latex	Y	N
Sulfa	Y	N
Codeine	Y	N

Any other known allergies:______________________________

Surgical History:
Please list all operations and date of surgery:______________________________________
____

Systems:

Do you have or have you ever had <u>long standing:</u>

cough	Y	N
sputum (phlegm)	Y	N
chest pain	Y	N
ankle swelling	Y	N
palpitation	Y	N
angina	Y	N
cramps in legs	Y	N
increase in appetite	Y	N
decrease in appetite	Y	N
nausea	Y	N
vomiting	Y	N

Alcoholic Beverages:
___never ___rarely ___moderate ___heavy

Use of Tobacco:
___ packs ___per day

Medications taken regularly:
____
____
____
____

Names of treating Physicians:
____
____

REVIEW OF SYSTEMS

PATIENT NAME: ______________________

DATE OF BIRTH: ______________________

CONSTITUTIONAL

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses/ contact lenses	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

ENT

Hearing loss	YES	NO
Ringing in ears	YES	NO
Earaches or drainage	YES	NO
Sinus problems	YES	NO
Nose Bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pains	YES	NO
Sudden heart beat changes	YES	NO
Swelling of feet or hands	YES	NO

RESPIRATORY

Frequent coughing	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or Vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements or constipation	YES	NO
Blood in stool	YES	NO
Stomach pain	YES	NO

GENITOURINARY

Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force of strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Male- testicular pain	YES	NO
Female- pain w/ periods	YES	NO
Female- irregular periods	YES	NO
Female- vaginal discharge	YES	NO

Female- # of pregnancies___
# of miscarriages___
Female- date of last pap smear ______
Female- findings of last pap smear __normal
__abnormal

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty in walking	YES	NO

SKIN

Rash or itching	YES	NO
Change in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

NEUROLOGICAL

Frequent or reccurring headaches	YES	NO
Light headed or dizzy	YES	NO
Convulsions or seizures	YES	NO
Numbness or tingling sensations	YES	NO
Tremors	YES	NO
Paralysis	YES	NO
Stroke	YES	NO

PSYCHIATIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Sleep problems	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Dry skin	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGIC/ LYMPHATIC

Slow to heal after cuts	YES	NO
Easily bruise or bleed	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusion	YES	NO
Enlarged glands	YES	NO

SIGNATURE: ______________________

DATE: ______________________

Systems (cont):

diarrhea	Y	N
constipation	Y	N
abdominal pain	Y	N
gas pain	Y	N
heartburn	Y	N
blood in stool	Y	N
headache	Y	N
dizziness	Y	N
fainting spells	Y	N
seizures	Y	N
muscle weakness	Y	N
numbness/tingling	Y	N
impaired hearing	Y	N
do you wear glasses	Y	N
do you wear contacts	Y	N
frequent urination	Y	N
burning urination	Y	N
difficulty urinating	Y	N
Foul smelling urine	Y	N
Color change in urine	Y	N
do you bleed easily	Y	N
do you bruise easily	Y	N
fever	Y	N
weight loss	Y	N
weight gain	Y	N
lack of energy	Y	N
do you sleep well	Y	N

Women Only:

vaginal bleeding	Y	N
vaginal discharge	Y	N
vaginal itching	Y	N

Women Only:

Do you take birth control pills?

___ yes ___ no

Number of years:___

Menstrual History:

age at onset: ___

regular: ___yes ___no

cycle: ___days (from start to start)

usual duration: ___days

heavy___ medium___ light___

pain or cramps: ___yes ___no

date of last period: __________

date of last pap smear: __________

Pregnancies:

how many pregnancies: ____

any complications with pregnancy

____yes ____no

Menopause

age and year in which periods stopped:

___age _____year

Family History: Put out Beside yes. Which Family member.

Have any of your family members been diagnosed with the following conditions? ie Father. Mother - M. Grandparent P. Grand Father Aunt or Uncle

Diabetes Y N Cancer Y N Stroke Y N

High Blood Pressure Y N Heart Disease Y N

(Please circle alive or deceased)

Is your mother: alive deceased Current Age? ___ (or age at death ___)

Is your father: alive deceased Current Age? ___ (or age at death ___)

How many TOTAL brothers and sisters? _________

How many are still living? ________

Patient or Guardian Signature________________________________Date____________