142 Hospital Perimeter Rd – Eatonton, Georgia 31042
Phone: (706) 485-1145 • Fax: (706) 485-6014
PhillipsFamilyMedicine.com
PFMPortal.com
info@phillipsfamilymedicine.com

Thank you for choosing Phillips Family Medicine!

Helpful information before your first appointment:

- Please be sure this packet is filled out as completely as possible.
- Please bring a current list of your medications and any immunization records you may have.
- Please be sure to arrive15 minutes prior to your appointment. (We need time to enter your information into the system before your provider can see you)
- Please bring a valid photo ID and your insurance card. (If you are using your health insurance)
- *****Co-payments, Deductibles, Co-Insurances, and all other amounts are due at the time of service.

*****Please ask to speak with a member of our billing staff if you are unable to make payment at the time of your visit.

New Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Previous Primary Care Provider ☐ None ☐					
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy ☐ ☐

Pharmacy Name	Pharmacy Location

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Please continue to the next page.

New Patient Information and Consent

Accident/Injury Information

Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

May we leave testing results or referral info in email or voicemail? ☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Phillips Family Medicine and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at PFM.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the PFM Notice of Privacy Practices.
4. I authorize payment of medical benefits to PFM physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice.

X _____ _____

Patient or Authorized Person's Signature Date

TO CURE SOMETIMES, TO HEAL OFTEN
EST 2005
PHILLIPS
FAMILY MEDICINE
TO CARE ALWAYS

Phillips Family Medicine Communication

Appointment Reminds:

I wish to be reminded of upcoming appointments via:

□ HOME PHONE (call)	□ CELL PHONE (call)	□ EMAIL	□ TEXT

Authorization to release medical information:

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

Phone Number: _____ Is it ok to leave a message? _____ Yes _____ No

Do you want Phillips Family Medicine, and all employees thereof, to be able to determine financial matters or medical care with any family members or emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information, below.

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	NAME	RELATIONSHIP	PHONE NUMBER
□ FINANCIAL □ MEDICAL			

Patient Consent for use and disclosure of protected health information:

With your consent, Phillips Family Medicine may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time. With your consent, Phillips Family Medicine may call, email or send mail to your home or office and leave a message about any items that assist the practice in carrying our TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent.

If you decline to sign this consent, we may decline to provide treatment for you.

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self Date

RIGHTS AND RESPONSIBILITIES

YOU HAVE A RIGHT:

- To be treated with respect, consideration, and dignity always.
- To receive assistance in a responsible manner
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

YOU HAVE A RESPONSIBILITY:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each visit, if asked.
- Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges for co-payments, deductibles, non-covered benefits, or services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

I have read and understand the office policy as stated above

_____ _____

(Patient's Printed Name) (Signature of patient or legal guardian)

_____ _____

Relationship to patient, if other than self Date

Patient Medical History

Today's Date: _____

Patient information

Patient Name	Date of Birth	Birth Sex ☐ M ☐ F	Nickname

Patient History

INDICATE ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

- ☐ Head/brain injuries or illnesses (e.g., concussion)
- ☐ Seizures, epilepsy
- ☐ Eye problems (except glasses or contacts)
- ☐ Ear and or hearing problems
- ☐ Heart disease, heart attack, bypass, or other heart problems
- ☐ Pacemaker, stents, implantable devices, or other heart procedures
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Chronic (long-term) cough, shortness of breath or other breathing problems
- ☐ Lung disease (e.g., asthma)
- ☐ Kidney problems, kidney stones, or pain/problems with urination
- ☐ Stomach, liver or digestive problems
- ☐ Diabetes or blood sugar problems
- ☐ Anxiety, depression, nervousness, or other mental health problems
- ☐ Fainting or passing out
- ☐ Dizziness, headaches, numbness, tingling, or memory loss
- ☐ Unexplained weight loss
- ☐ Stroke, mini-stroke (TIA), paralysis, or weakness
- ☐ Neck or back problems
- ☐ Bone, muscle, joint or nerve problems
- ☐ Blood clots or bleeding problems
- ☐ Cancer
- ☐ Chronic (long term) infection or other chronic diseases
- ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring

Allergies (include medication, food, latex and environmental allergies)

No known allergies ☐

Allergy to:			
Severity:	☐ Mlld ☐ Moderate ☐ Severe	☐ Mlld ☐ Moderate ☐ Severe	☐ Mlld ☐ Moderate ☐ Severe
Reaction:			

Current Medication (include non-prescription products)

No current medications ☐

1.	3.	5.	7.
2.	4.	6.	8.

Preferred Pharmacy ☐ ☐

Pharmacy Name	Pharmacy Location

Procedures / Surgeries

No procedures or surgeries ☐

Surgery / Procedure #1	Approximate Date	Surgery / Procedure #3	Approximate Date
Surgery / Procedure #2	Approximate Date	Surgery / Procedure #4	Approximate Date

PHILLIPS FAMILY MEDICINE

Patient Medical History — Page 2

Today's Date: _____

Patient Name	Date of Birth

Preventative Screening

Not applicable ☐

Have you had a colonoscopy? ☐ Yes ☐ No If yes, date:

Have you had a mammogram? ☐ Yes ☐ No If yes, date:

Women's Health

Not applicable ☐

When was your most recent menstrual cycle? Date:

Family History

Mother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Father	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Sister	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Brother	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandmother (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (M)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A
Grandfather (P)	☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other (specify):	☐ N/A

Other Health Issues

Do you drink alcohol? ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor _____ per week

Do you smoke cigarettes? ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use other forms of tobacco? ☐ Yes ☐ No ☐ Pipe ☐ Cigar ☐ Snuff/Chew

Do you vape or use an e-cigarette? ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Marijuana / recreational drug use? ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Immunizations

Influenza (18 years of age and older) ☐ Yes ☐ No If yes, date: _____

Pneumoccal (65 years of age and older) ☐ Yes ☐ No If yes, date: _____

Tetanus ☐ Yes ☐ No If yes, date: _____

COVID-19 ☐ Yes ☐ No Number of shots: _____ Date of most recent: _____