Physicians and Midwives of Macon
1062 Forsyth St, Suite 3B, Macon, Ga 31201
(478) 743-3454
www.physiciansandmidwivesofmacon.com/

## PATIENT INFORMATION

Patient Name: _____ _____ _____Date of Birth:_____

Social Security #:_____ _____Race: _____Marital Status:_____

Mailing Address:_____ _____ Apt #:_____City:_____State:_____Zip:_____

Email Address:_____ _____ _____Last Flu Vaccine (Mo/Yr):___

Home Phone:_____ Cell Phone:___ _____Work Phone:_____

Pharmacy Name & Location: _____ Primary Care Physician:_____

Employer Name:_____ _____ _____Occupation:_____

Employer Address:_____ _____ City:_____State:_____Zip:____

## INSURANCE INFORMATION

Primary Insurance Carrier:_____Policy Holder Same As Patient ☐

Policy Holder Name: _____ Date of Birth:_____Social Security #:_____

Employer Name:_____Occupation:_____

Employer Address:_____City:_____State:_____Zip:_____

Secondary Insurance Carrier:_____Policy Holder Same As Patient ☐

Policy Holder Name: _____ Date of Birth:_____Social Security #:_____

Employer Name:_____Occupation:_____

Employer Address:_____City:_____State:_____Zip:_____

## EMERGENCY INFORMATION

Emergency Contact Name:_____ _____

Phone #:_____

Relationship:_____

SIGNATURE:_____ DATE:_____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Please Complete Reverse Side ⇨

# Physicians and Midwives of Macon

*AUTHORIZATIONS*

- I hereby authorize and request medical treatment necessary for the care of the above named patient as determined by the Physician, including checking my external prescription history.
- I authorize the release of all medical records and appeals to the referring physicians, family physicians, and to my insurance company, if applicable. I allow the fax transmittal of my records if necessary. I also acknowledge that my doctors office will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.
- I acknowledge full responsibility for any services rendered by Physicians and Midwives of Macon. I understand that any co-payment I have with my insurance company is due at the time of service. I understand that I am financially responsible for payment of any co-insurance, un-met deductible, or non-covered services, as deemed by my insurance company, within a timely manner.
- I further authorize and request that insurance payments be made directly to Physicians and Midwives of Macon for all services rendered.

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*LAB WAIVER*

Certain lab specimens are sent to outside labs for processing. We will send the specimen to the laboratory that participates with your insurance carrier, to the best of our knowledge. If your specimen is sent to the wrong lab, Physicians and Midwives of Macon will not be responsible for any fees incurred for processing. I understand that it is my responsibility to know which laboratory my insurance authorizes, and to notify Physicians and Midwives of Macon staff of this information.

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*AUTHORIZATION TO OBTAIN INFORMATION*

I authorize the following individuals the right to obtain any information; including: lab results, appointment information, or any other diagnostic testing performed by Physicians and Midwives of Macon.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

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*ACKNOWLEDGEMENT OF PRIVACY NOTICES (HIPAA) AND DISCLOSURE OF HEALTH INFORMATION*

I understand that the patient's health information is private and confidential. I understand that Physicians and Midwives of Macon work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Physicians and Midwives of Macon may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it

Physicians and Midwives of Macon have a detailed document called the "Notice of Privacy Practices" in which contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

My signature below indicates that I have been given the opportunity to review a current copy of Physicians and Midwives of Macon "Notice of Privacy Practices", and that I agree to Physicians and Midwives of Macon to use and disclose the patient's health information to carry out treatment, payment from insurance companies, and all healthcare operations.

SIGNATURE:_____ DATE:_____

Patient Name: _____

Today's Date:_____

## Medication List

| Prescription and over the counter | Strength | Frequency |
|---|---|---|
| | | |
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## Drug Allergies

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|---|---|
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## Surgical History Since Last Visit

| Date | Type of Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Patient Name:**

MYRIAD myRisk® Hereditary Cancer

**Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know.**

**Relatives to consider:** Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

## Do you have a personal history of:

| | | |
|---|---|---|
| **Breast, ovarian, or pancreatic cancer** diagnosed at **any age**? | ☐ YES | ☐ NO |
| **Colorectal or uterine cancer** diagnosed at **age 64 or younger**? | ☐ YES | ☐ NO |

## Do you have a family history of:

| | | |
|---|---|---|
| **Breast cancer** diagnosed at age **49 or younger**? | ☐ YES | ☐ NO |
| **Ovarian cancer** diagnosed at **any age**? | ☐ YES | ☐ NO |
| **Pancreatic cancer** diagnosed at **any age**? | ☐ YES | ☐ NO |
| **Uterine cancer** diagnosed at **age 49 or younger**? | ☐ YES | ☐ NO |
| **Colorectal cancer** diagnosed at age **49 or younger**? | ☐ YES | ☐ NO |

If you answered "Yes" to any of the questions above, show this card to your healthcare provider today and ask to discuss hereditary cancer testing.