Altamaha Primary Care

Patient Information Form

1. PATIENT INFORMATION

Patient Name: ____

Date of Birth: _______________ Age: __________ Sex: _______________

Address: ____

City: ___________________________ State: ________ Zip: ________________

Email: ____

Home Phone: _________________________ Work Phone: _____________________________

Cell Phone: ___________________________

Social Security Number: ___________________ Driver's License Number: __________________

Employer Name & Address: ____

2. SPOUSE INFORMATION

Spouse Name: ____

Spouse Social Security Number: _________________ Spouse Date of Birth: _________________

Spouse Address: ____

Spouse Employer Name & Address: ____

Spouse Phone Number: ____________________ Spouse Work Phone: ___________________

3. RESPONSIBLE PARTY

Person Responsible for Account: ____

Relationship: ____________________________ Occupation: _____________________________

Address: ____

Phone Number: ___________________________ Work Phone: ___________________________

Social Security Number: ____________________ Driver's License: _______________________

Employer Name & Address: ____

4. EMERGENCY INFORMATION

Person to contact in case of emergency: ____

Phone Number: ________________________ Relationship to Patient: ___________________

5. IF STUDENT, PLEASE LIST PARENT'S NAME & ADDRESS

____

____

Pharmacy: _______________________________

Altamaha Primary Care

Insurance Information

**As a courtesy to our patients, we will file your insurance claim at no charge however, this information must be complete.*

6. INSURANCE INFORMATION
   Primary Insurance is through: Self ____ Spouse ____ Mother ____ Father ____
   Name of Insured: _________________________ Social Security Number: __________________
   Date of Birth: ____
   Name of Insurance Company: ____
   Group #: __________________ ID #: ____________________ Policy #: ____________________
   Billing Address: ____
   Phone Number: ____

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7. MEDIGAP (SECONDARY INSURANCE)
   Name of Beneficiary: ____
   Health Insurance Company: ____
   Medigap Policy Number: ____

Altamaha Primary Care

MEDICAL HISTORY

Name: ____ Date: ______________________

1. Check all of the following that you have or have had:

__Glaucoma	__Rheumatic Fever	__Bleeding Problems	__Breast Problems
__Hearing Loss	__High Cholesterol	__Inflammatory Bowel	__Kidney Problems
__Thyroid Problems	__Stomach Problems	__Poor Circulation	__Lumps or Bumps
__Hormonal Problems	__Trauma	__Arthritis	__Headaches
__Pneumonia	__Gallbladder Problems	__Varicose Veins	__Migraines
__Emphysema/COPD	__Hiatal Hernia	__Skin Growths	__Angina
__Asthma	__GI Bleed	__Abdominal Pain	__Seizures
__Tuberculosis	__Colon Polyps	__AIDS	__Skin Problems
__High Blood Pressure	__Hepatitis	__Herpes	__Psoriasis
__Heart Attack	__Hernias	__Venereal Disease	__Cancer
__Abnormal Pap	__Hemorrhoids	__TMJ Problems	__Blood Transfusion
__Ob/Gyn Problems	__Diabetes		

Additional remarks:
____
____
____

2. Please list all previous surgeries:

__Hernia Surgery	__Pediatric Surgery	__Hand Surgery	__Gallbladder Surgery
__Lung Surgery	__Heart Surgery	__Foot Surgery	__Vascular Surgery
__Kidney Surgery	__Appendectomy	__Tonsillectomy	__Colon Surgery
__Surgery for bowel obstructions		__Surgery for Trauma	__Laparoscopic Surgery
__Hysterectomy or Ovary Surgery		__Tubal Ligation	__Cancer Surgery
__Testicular Surgery	__Ob/Gyn Surgery	__Breast Surgery	__Skin Cancer Surgery
__Head and Neck	__Cosmetic Surgery	__Plastic Surgery	__Ear Surgery
__Eye Surgery	__Vasectomy		

Additional remarks:
____
____

3. Family History (Check all that apply):

__Heart Disease __Migraine __Hyperlipemia __Diabetes

__Stroke __Cancer __High Blood Pressure

Additional Remarks:

____

____

4. Do you smoke? (circle) **Yes** **No** If "YES", how many packs per day?___ Number of years?__
   Do you drink? (circle) **Yes** **No** If "YES", how many drinks a day?____ Number of years?__

5. Do you have allergies to any medications? Yes No If "Yes" please list.
   ____

6. Review of Systems (Check all that apply):

Constitutional Systems:	Cardiovascular:	Gastrointestinal:	Musculoskeletal:
Have you had recent fever? ___ Have you had recent chills? ___ Have you had constipation? ___ Have you had recent weight loss? ___ Have you had diarrhea? ___	Do you have a heart murmur? __ Do you have heart disease? ___ Chest pressure, tightness, or pain? ___ Palpitations? ___ Skipped beats? ___ Leg pain when walking? ___ Blood clots or inflammation in leg veins? ___ Varicose veins? ___ Swollen ankles or feet? ___ Fainting? ___ Do you sit up to sleep? ___ Out of breath quickly? ___ Bleeding Problems? ___	Poor Appetite? ___ Heart Burn? ___ Nausea or Vomiting? ___ Vomiting blood or coffee ground type material? ___ Stomach Pain? ___ Ulcers? ___ Liver disease or jaundice? ___ Gallstones? ___ Change in bowel habits? ___ Pancreas problems? ___ Black or tarry stools? ___ Blood in stools? ___ Do you use enemas or Laxatives ___ Greasy, frothy stools? ___ Rectal pain, burning? ___	Physically Handicapped? ___ Muscle Problems? ___ Joint Problems? ___ Trouble with walking? ___ Neck problems? ___
Ears, Nose, Mouth, Throat:			**Skin:**
Nose bleeds? ___ Hoarseness? ___ Swallowing Problems? ___ Mouth Problems? ___ Ear Problems? ___			Moles that are changing? ___ Moles with different colors? ___ Moles with irregular borders? ___
Eyes:	**Respiratory:**		**Neurological:**
Do you wear contacts Or glasses? ___ Vision Changes? ___ Blurred Vision? ___ Double Vision? ___ Eye Surgery? ___ Episodes like a window shade coming over your eyes? ___	Do you have a cough? ___ Productive cough? ___ Cough blood? ___ Wheezing? ___ Breathing problems? ___		Fainting? ___ Numbness anywhere? ___ Convulsions or Seizures? ___ Tremors? ___ Paralysis or weakness? ___ Coordination Problems? ___ Stroke? ___
Hematology/Lymphatic:	**Allergic/Immunologic:**	**Genitourinary:**	**Psychiatric:**
Do you have a blood disorder? ___ Do you, or have you ever had abnormal or enlarged lymph nodes? ___ Have you ever had Lymphoma or Leukemia? ___ Are you taking any blood-Thinning pills? ___	Do you have any allergic Conditions? ___ Do you have any Immunological conditions? ___ Do you have a skin rash? ___	Prostate Problems? ___ Menstrual Problems? ___ Vaginal discharge? ___ Testicular pain or swelling? ___ Sexual Problems? ___ Penile Discharge? ___ Impotency? ___ Do you have any urinary or Bladder problems? ___	Do you have a mental disorder or disease? ___ Do you have mood swings? ___ Do you suffer from depression? ___ Do you, or have you ever had An alcohol problem? ___ Do you, or have you ever had a drug problem? ___

7. Please list your current medications including the amount you take each day (dosage), how you take this medication (route), and the number of times you take this medication each day (frequency):

Name of Medication	Amount (Milligrams)	How is it given? (Mouth, Injection or Skin Patch?)	How many times a day do you take this medication?

Thank you for taking the time to fill out this form. We appreciate your cooperation so that we may continue to provide the best medical care for you.

Altamaha Primary Care

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Altamaha Primary Care may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Altamaha Primary Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Altamaha Primary Care 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 the Privacy Officer, Altamaha Primary Care, 248 NE Broad St, Jesup, GA 31546.

With my consent, Altamaha Primary Care may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Altamaha Primary Care may mail to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With my consent, Altamaha Primary Care may email to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Altamaha Primary Care restrict how it used or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Altamaha Primary Care's use and disclosure of 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, Altamaha Primary Care may decline to provide treatment to me.

_________________________________ ___________________
Signature of Patient or Legal Guardian Date of Birth

_________________________________ ___________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

Altamaha Primary Care may discuss my medical condition/information with the following:

Name of Person: _________________________ Relationship: _____________________________

Person to contact in case of emergency:

Name: ___________________________ Phone: _________________________________

Revised 12/16/2021

Altamaha Primary Care

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept cash, personal checks, Visa and Master Card. <u>If you are a new patient, we require that your first visit be paid by cash, Visa, or Master Card.</u>
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the Doctor/Practitioner. In other words: If you agree to have your insurance pay the Doctor/Practitioner directly, and your insurance company does not pay the practice within a reasonable period, Altamaha Primary Care will require full payment from you directly. If we later receive payment from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment or percentage of the overall cost at the time of your visit.
3. <u>If you are insured by a plan that we do not have a prior agreement with, we will prepare and send a claim for you. The total charge for your visit/care will be due at the time of service.</u> If your insurance provider sends us payment for your visit/care at a later time/date, we will refund you in the form of a check.
4. Not all insurance plans cover all services. In the event your insurance plan determines that a service will not be covered, you will be responsible for the complete charge/cost. Payment is due upon receipt of a billing statement from our office.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

__________________________________ ___________________

Signature of Patient (or responsible party) Date

____

Print Name of Patient

IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO RESCHEDULE OR CANCEL, YOU WILL BE CHARGED A $50.00 NO SHOW FEE

ALL RETURNED CHECKS WILL INCUR A $25.00 RETURN FEE

Altamaha Primary Care

CONSENT FOR EXAMINATION

I will be seen by a nurse practitioner who acquired advanced education, special knowledge, and skills in the evaluation, diagnosis, treatment, education, risk assessment, health promotion, case management, coordination of care and counseling in the primary care of adults and adolescents.

I_______________________________________, hereby request that the Nurse Practitioner examine and treat me. If appropriate, suitable medication(s) will be supplied, re-evaluated, and changed as recommended.

I realize that if tests are taken for sexually transmitted diseases that positive results of some tests must be reported to the public health agencies as required by law.

Signature_________________________________ Date___________________________

Witness__________________________________ Date___________________________

Altamaha Primary Care

RECORDS RELEASE

Patient Name: ______________________________ Social Security Number: ___________________

Date of Birth: _______________________________ Phone Number: ___________________________

Address: ____ City/State/Zip: _________________________

I authorize Altamaha Primary Care to release or obtain my medical information. I also give Altamaha Primary Care permission to speak with any provider/physician at any time in reference to me and my medical condition(s).

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Release Records TO and/or FROM:

Name: ____

Phone: __________________________________ Fax: ____________________________________

Address: ____

City/State/Zip: ____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Altamaha Primary Care. I understand that the revocation will not apply to information that has already been released in response to the authorization I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to consent a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do herby acknowledge that I am familiar with, and fully understand the terms and conditions of this authorization.

____ ___________________

Signature of Patient/Authorized Representative Date

Revised 12/16/2021