ADULT MEDICINE OF MARIETTA, P.C.

790 Church Street, Suite 250, Marietta GA 30060 Ph: 678-797-8201 Fax: 678-290-8325

Adult Medicine of Marietta Established Patient Paperwork

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DEMOGRAPHIC INFORMATION

Patient Information			
Name (Last, First Middle)	SS#	Birth Date	Sex

Local Address	Secondary/ Billing Address (If applicable)
City, State Zip	City, State Zip
Home Phone	Home Phone
Primary Employer	Secondary Employer (If applicable)
Address	Address
City State Zip	City, State Zip
Work Phone	Work Phone

Responsible Party Information			
Name (Last, First Middle)	SS#	Birth Date	Sex

Local Address	Secondary/ Billing Address (If applicable)
City, State Zip	City, State Zip
Home Phone	Home Phone
Relationship to Patient	

Pharmacy Information	
Name of Pharmacy	Phone
Address	Fax
City, State Zip	

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Name: ____________________________ Date of Birth: __________________________

DEMOGRAPHIC INFORMATION (cont)

Emergency Contact Information	
Name (Last, First Middle)	Home Phone
Relationship to Patient	Cell Phone

INSURANCE INFORMATION

Primary Insurance	
Name of Insurance Company	Policy #
Name of Insured	Group #
Address of Insurance Company	Co-pay Amount
City, State Zip	Deductible Amount
Relationship to Patient	Effective Date and Expiration Date

Secondary Insurance	
Name of Insurance Company	Policy #
Name of Insured	Group #
Address of Insurance Company	Co-pay Amount
City, State Zip	Deductible Amount
Relationship to Patient	Effective Date and Expiration Date

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I acknowledge that no assurance or promises have been given the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

I authorize the release of any medical or other information necessary to process this claim.

____ ________________________

Signature of Patient/ Guardian Date

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Name: ____________________________ Date of Birth: __________________________

COMMUNICATION AUTHORIZATION

Patient Information	
Name (Last, First Middle)	Birthdate
Street Address	Home Phone Number
City, State Zip	Alternative Phone Number

I authorize Adult Medicine of Marietta, P.C. to disclose Protected Health Information (HPI) as follows:

☐ Disclosure of PHI referencing my health care if permitted with the following person(s):

____________________________________ ______________________________________
Authorized Person's Name Relationship

____________________________________ ______________________________________
Authorized Person's Name Relationship

____________________________________ ______________________________________
Authorized Person's Name Relationship

☐ Telephone Contact:
Preferred telephone number: ________________________________

☐ Leave message on the answering machine/voice message system
Yes _______ or No __________

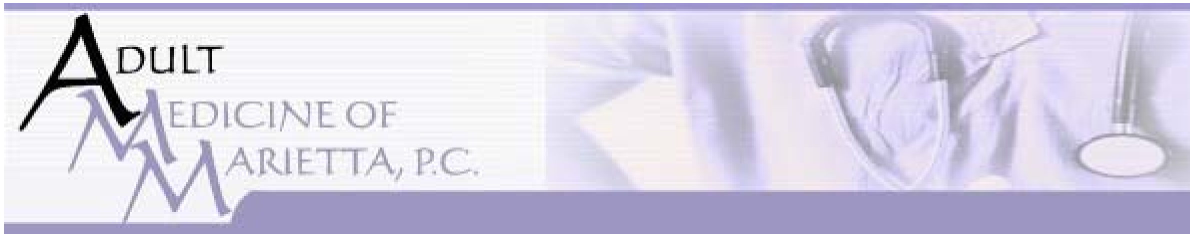
☐ Leave message with any person who answers the telephone
Yes _______ or No __________

Expiration Date: (specify date or event) ____

_________________________________ or ______________________________________
Signature of Patient Printed Name of Authorized Personal Representative

_________________________________ ______________________________________
Date of Authorization Signature of Authorized Representative

_________________________________ ______________________________________
Witness Relationship to Patient



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FINANCIAL POLICY

This is an agreement between Adult Medicine of Marietta PC, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to Adult Medicine of Marietta PC.

By executing this agreement, you are agreeing to pay for all services that are received.

- **Insurance:** We will file your insurance for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services. ***Note: Many plans do not pay for services rendered by providers not designated with the carrier as your Primary Care Physician under your plan. In this case, you will be financially responsible for all charges rendered.***
- **Payment options if you have no insurance:** Payment by cash, check or credit card is required the day the service is rendered. Patients not covered by insurance are eligible for a 20% discount on services paid the day they are rendered.
- **Missed Appointments Fees:** If you do not show up on time for a Physical Exam appointment, or cancel a Physical exam appointment with less than 24 hours notice, there will be a $25.00 missed Physical Exam appointment fee applied to your account. This fee must be paid before a new Physical Exam appointment is scheduled. Missed appointment fees for Diagnostic Testing performed in this office will be outlined in the Diagnostic Testing Consent form specific to the scheduled test.
- **Insufficient Funds Charge:** There is a fee of $25.00 for any checks or debits returned by the bank due to insufficient funds.
- **Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show any previous balance, new charges added to the account, the finance charge, if applicable, any payments or credits applied to your account during the month.
- **Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item becomes the responsibility of the patient. The **FINANCE CHARGE** will be one and one-half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $0.50.
- **Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred (up to 33% of the past due balance). If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cobb County, Georgia.
- **Effective Date:** Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Name: ______________________________ Date of Birth: ______________________________

______________________________ ______________________________
Signature Date

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PRIVACY NOTICE

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staff. In general, HIPAA was enacted to establish national standards to:

- Give patient more control over their health information
- Set boundaries for the use and release of health records
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information
- Hold violators accountable, with civil and criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosure to protect the public health

The HIPAA rules require that our practice offer all of our patients that we see after April 14, 2003 the opportunity to review the Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that you have been given the opportunity to view the Notice of Privacy Practices. You are entitled to a personal copy for the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

I acknowledge that I may receive a copy of Adult Medicine of Marietta PC's Notice of Privacy Practices and have been given an opportunity to ask questions.

_____________________________________ _________________________________

Signature Date

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Name: ______________________________ Date of Birth: ___________________________

DETAILED PATIENT INFORMATION

Please list any medical problems/ diseases that you have:

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Please list all medications, herbs, vitamins and over-the-counter products you are taking:

Name	Dose/Strength	How often you take it

ADULT MEDICINE OF MARIETTA, P.C.

Name: ______________________________ Date of Birth: ____________________________

Please list all allergies to medications, foods, chemicals, plants and the reactions you have:

Allergy	Reaction

FAMILY HISTORY

Please list all family members including mother, father, sisters, and brothers:

☐ Check here if adopted

Family member	Name	Medical Problems	Age	Deceased

Any diseases/illnesses that run in the family (Cancer, Diabetes, Heart Disease, etc):

________________________________ ____

________________________________ ____

________________________________ ____

Name: ______________________________ Date of Birth: ____________________________

SURGICAL HISTORY

Please list all surgeries or procedures you have had done:

Date	Type of Surgery/Procedure	Reason for Procedure	Hospital	Name of Surgeon

Please list all medical specialists that you see:

Name of Doctor	Specialty

Name: ______________________________ Date of Birth: ____________________________

SOCIAL HISTORY

Name: ____________________________ Date of Birth: _________________________
Birthplace: ________________________ Level of education completed: ___________
What you do for work: ____

Marital Status
Current status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed
Do you live alone: ☐ Yes ☐ No
Previously widowed: ☐ Yes ☐ No Previously divorced: ☐ Yes ☐ No

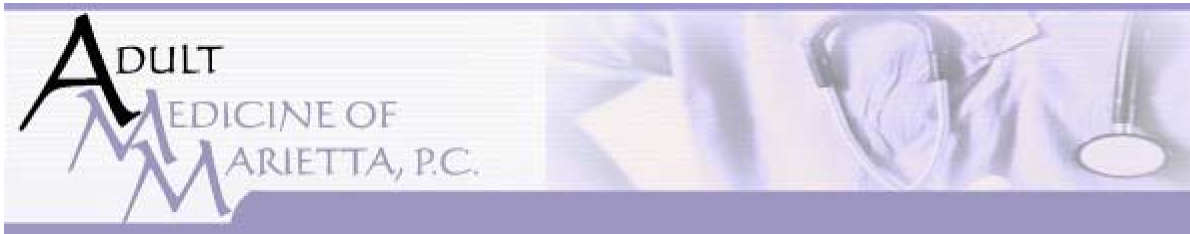
Children
☐ Yes ☐ No
Number of sons: __________________ Number of daughters: _____________________

Tobacco
Are you a smoker: ☐ Yes ☐ No ☐ Former Passive smoker exposure: ☐ Yes ☐ No
Type: _________________________ Packs/day ______________________________
Years smoked: _______ Year Quit: _____ Ever tried to quit: ☐ Yes ☐ No

Caffeine
Do you drink caffeine: ☐ Yes ☐ No
Type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Tablets ☐ Tea

Alcohol
Do you drink alcohol: ☐ Yes ☐ No ☐ Formerly ☐ Year Quit: _________
Type: ☐ Beer ☐ Hard Liquor ☐ Wine
Frequency: _____________ Amount: ____________ Last drink: ________________

Lifestyle
Activity level: ☐ Sedentary ☐ Moderate ☐ Vigorous
Health club member: ☐ Now ☐ Previously ☐ Never
Type of exercise: ____
Exercise Frequency: _________________________ Hours/week: _____________________
Hobbies/Activities: ____
Specific type of diet: ☐ Low fat ☐ Low carb ☐ Diabetic ☐ Weight watchers
Animals in the home ☐ Yes ☐ No Type: _____________________________
Are you the one who cleans up after the animal: ☐ Yes ☐ No



Name: ______________________________ Date of Birth: ____________________________

Recent Travel

Any recent travel out of the state ☐ Yes ☐ No Where: ___________________________
Any recent travel out of the country ☐ Yes ☐ No Where: ___________________________

Safety

Are there smoke detectors in the home?	☐ Yes	☐ No
Are there carbon monoxide detectors in the home?	☐ Yes	☐ No
Is there radon in the home?	☐ Yes	☐ No
Do you have firearms in the home?	☐ Yes	☐ No
Do you wear a seatbelt?	☐ Yes	☐ No

Advanced Directives in Place

Mark the advanced directives that you currently have in place:
☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy
Do you agree to a transfusion? ☐ Yes ☐ No

Name: ______________________________ Date of Birth: ____________________________

HEALTH MAINTENANCE

Please fill in the date of your most recent health maintenance event (if applicable):

Event	**Date of Last**
Colonoscopy/ GI procedure	
Stress test/ Cardiac procedure	
Echocardiogram	
Eye exam	
Skin exam	
Mammogram/ Breast exam	
Pap-smear	
PSA/ Prostate exam	
Rectal exam/ Stool cards/ FOBT	
Bone Density	

Vaccine/ Immunization	**Date of Last**
Tetanus (Td)	
Pneumonia vaccine	
Flu vaccine	
Hepatitis A vaccine	
Hepatitis B vaccine	
TB/ PPD (Tuberculosis screening)	
MMR (Measles, Mumps & Rubella)	
Zostavax	

Infectious Disease History

Do you have any history of blood/ blood product transfusion? If so, when and for what reason?
____
____
____

Name: ______________________________ Date of Birth: ___________________________

Do you have any history of tick bites, Lyme disease, Rocky Mountain Spotted Fever, or Ehrlichiosis? If so, please explain:

____
____
____

Have you ever had a positive PPD test (Tuberculosis screening)? If so, what happened as a result of that positive test?

____
____
____

Any concern for possible HIV infection? If so, please explain:

____
____
____

Gynecological History (Females)

Number of Pregnancies	Number of Premature Births	Number of C-Sections	Number of Vaginal Births	Number of Life Births	Number of Births at Term	Number of Children Currently Living

Number of Ectopic Pregnancies	Number of Miscarriages	Number of Abortions

☐ Check here if currently pregnant

Name: ____________________________ Date of Birth: __________________________

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past month?

CONSTITUTIONAL

Activity change	No	Yes
Chills	No	Yes
Decreased appetite	No	Yes
Fatigue	No	Yes
Fever	No	Yes
Insomnia	No	Yes
Irritability	No	Yes
Malaise/ feeling unwell	No	Yes
Night sweats	No	Yes
Abnormal paleness	No	Yes
Weakness	No	Yes
Weight gain	No	Yes
Weight loss	No	Yes

HEENT

Headache	No	Yes
Eye burning	No	Yes
Double vision	No	Yes
Eye discharge/ drainage	No	Yes
Eye dryness	No	Yes
Foreign body sensation	No	Yes
Eye itching	No	Yes
Rapid eye movements	No	Yes
Eye pain	No	Yes
Sensitivity to light	No	Yes
Eye redness	No	Yes
Visual halloes or blind spots	No	Yes
Spots/ floaters	No	Yes
Tearing	No	Yes
Glasses	No	Yes
Contacts	No	Yes
Visual Loss	No	Yes

HEENT continued…

Radical keratotomy	No	Yes
Lasik	No	Yes
Last eye exam		
Ear discharge	No	Yes
Cerumen/ ear wax	No	Yes
Ear fullness	No	Yes
Hearing loss	No	Yes
Noise exposure	No	Yes
Ear pain	No	Yes
Tinnitus/ ringing in the ears	No	Yes
Vertigo/ dizziness	No	Yes

NOSE AND SINUS

Decreased smell	No	Yes
Nasal discharge/ drainage	No	Yes
Nose bleeds	No	Yes
Facial pain	No	Yes
Infections	No	Yes
Nasal congestion	No	Yes
Sneezing	No	Yes

Name: ______________________________ Date of Birth: ___________________________

THROAT AND MOUTH

Taste change	No	Yes
Voice change	No	Yes
Cold sores	No	Yes
Difficulty swallowing	No	Yes
Hoarseness	No	Yes
Lump sensation	No	Yes
Pain when swallowing	No	Yes
Post nasal drip	No	Yes
Sore tongue/ tongue lesions	No	Yes
Sore throat	No	Yes
Tooth pain/ dentures/ plates	No	Yes

VASCULAR

Cramping in legs when walking	No	Yes
Blueing of the hands/ feet	No	Yes
Flushing or redness of hands/ feet	No	Yes
Cool extremities	No	Yes
Swelling of hands, feet or legs	No	Yes
Pain in extremities	No	Yes
Ulcers in legs, feet and arms	No	Yes
Varicose veins	No	Yes
Blood clots	No	Yes

RESPIRATORY/ THORAX

Rapid breathing	No	Yes
Cough	No	Yes
Chest pain	No	Yes
Frequent respiratory infections	No	Yes
Coughing up blood	No	Yes
Known TB exposure	No	Yes
Positive PPD/ TB test	No	Yes
Pain with breathing "stitch"	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

CARDIOVASCULAR

Chest pain	No	Yes
Shortness of breath at rest	No	Yes
Shortness of breath on exertion	No	Yes
Sleep sitting up to breathe	No	Yes
Shortness of breath at night- causes awakening	No	Yes
Swelling of hands and legs	No	Yes
Nighttime urination	No	Yes
Palpitations/ rapid heart beat	No	Yes
Passing out	No	Yes

GASTROINTESTINAL

Abdominal mass/ growth	No	Yes
Abdominal pain	No	Yes
Altered bowel habits- change from normal	No	Yes
Not eating or poor appetite	No	Yes
Black, tarry stools	No	Yes
Bloating and feeling of fullness	No	Yes
Blood in stool	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Difficult or painful swallowing	No	Yes
Flatulence/ gas	No	Yes
Jaundice/ yellow/ history of hepatitis	No	Yes
Indigestion/ heartburn	No	Yes
Throwing up blood	No	Yes
Nausea	No	Yes
Weight loss	No	Yes
Hemorrhoids	No	Yes
Rectal bleeding	No	Yes
Reflux	No	Yes
Vomiting	No	Yes

Name: ______________________________ Date of Birth: ____________________________

GENITOURINARY

Back pain/ flank/ side pain	No	Yes
Change in urine color/ cloudy urine	No	Yes
Urgency to urinate	No	Yes
Decreased stream or low urine output	No	Yes
Pain when urinating	No	Yes
Foul urine odor	No	Yes
Urinating frequently	No	Yes
Mass in groin	No	Yes
Blood in urine	No	Yes
Hesitancy or difficulty urinating	No	Yes
Urine leakage/ incontinence	No	Yes

History of passing a kidney stone	No	Yes
Urgency to urinate	No	Yes

MALE/ MEN TO COMPLETE

Are you circumcised?	No	Yes
erectile pain	No	Yes
Penile discharge	No	Yes
Blood in your stream	No	Yes
Scrotum/ testicular pain	No	Yes
Scrotum/ testicular mass	No	Yes
Hydrocele/ fluid around testes	No	Yes
History of Herpes Genitalia	No	Yes
Problems with fertility	No	Yes
Have you ever been treated for a sexually transmitted disease?	No	Yes
Describe your sexual function		
Normal		
Decreased		

WOMEN TO COMPLETE

Age of first period		
Last menstrual period		
Frequency of menstrual cycles		
Are you post-menopausal?	No	Yes
Are you on hormones?	No	Yes
Have you previously used hormones?	No	Yes
Have you ever used birth control?	No	Yes
Have you ever had an abnormal pap?	No	Yes
Do you do self breast exams?	No	Yes
Lack of libido	No	Yes
Nipple discharge	No	Yes
Breast lumps	No	Yes
Pain with sexual intercourse	No	Yes
History of uterine fibroids	No	Yes
Problems with infertility	No	Yes
Ovarian cysts	No	Yes
Sexual dysfunction	No	Yes
Vaginal itching	No	Yes
Vaginal discharge	No	Yes

METABOLIC/ ENDOCRINE

Voice changes	No	Yes
Cold intolerance/ feeling cold	No	Yes
Heat intolerance/ feeling hot	No	Yes
Hair loss	No	Yes
Coarse hair	No	Yes
Abnormal glucose/blood sugar tests	No	Yes
Abnormal fat distribution	No	Yes
Abnormal hair distribution	No	Yes
Chronically overweight	No	Yes
Chronically underweight	No	Yes
Darkening of skin	No	Yes
History of gout	No	Yes
Excessive perspiration	No	Yes
Excessive hunger or thirst	No	Yes
Generalized weakness	No	Yes
Gestational diabetes	No	Yes
Goiter	No	Yes
Gynecomastia/ male breast enlargement	No	Yes
Low sugar reactions	No	Yes
Increase in size of feet/ hands	No	Yes

Name: ____________________________ Date of Birth: __________________________

NEURO/ PSYCHIATRIC

Language disorder/ Difficulty talking	No	Yes
Unclear pronunciation	No	Yes
Focal weakness	No	Yes
Difficulty walking	No	Yes
Headaches	No	Yes
Incontinence	No	Yes
In-coordination	No	Yes
Lightheadedness/ dizziness	No	Yes
Loss of consciousness/ fainting	No	Yes
Memory loss	No	Yes
Tingling/ numbness	No	Yes
Seizures	No	Yes
Speech changes	No	Yes
Tremors	No	Yes
Vertigo/ Hx of Meniere's	No	Yes
Visual changes	No	Yes
Lack of concentration	No	Yes
Do you have any anxiety?	No	Yes
Do you feel fearful?	No	Yes
Do you feel excessively happy?	No	Yes
Do you feel paranoid?	No	Yes

DERMATOLOGIC

Acne	No	Yes
Contact allergies	No	Yes
Hx of excessive sun exposure	No	Yes
Frequent skin infections	No	Yes
Hair loss	No	Yes
Women: facial hair	No	Yes
Nail changes (brittle)	No	Yes
Change in skin color	No	Yes
Severe itching	No	Yes
Excessive sweating	No	Yes
Sensitivity to light	No	Yes
Rash	No	Yes
Skin lesions: tags, moles, freckles, birthmarks	No	Yes

MUSCULOSKELETAL

Back pain- neck, mid, low back	No	Yes
Bone/ joint swelling or pain	No	Yes
Hands/ wrist/ elbow shoulder/ hips/ feet/ ankle swelling or pain	No	Yes
Muscle pain/ weakness	No	Yes

HEMATOLOGIC

Easy bruising	No	Yes
Easy bleeding	No	Yes
History of blood clots	No	Yes
Anemia or low blood count	No	Yes
Swollen lymph nodes	No	Yes

IMMUNOLOGIC

Asthma	No	Yes
Hay fever	No	Yes
Hives	No	Yes
Anaphylaxis	No	Yes
Contact dermatitis/ rashes/ metal allergy	No	Yes
Food allergies	No	Yes
"Bee" sting allergy	No	Yes
If yes, reaction type:		
Environmental allergies: pollen, pollution	No	Yes
Animals at home	No	Yes
Animals in the work place	No	Yes
Chemicals in the home	No	Yes
If yes, type:		
Chemicals in the work place	No	Yes
If yes, type:		