



Welcome to North Georgia Family Medicine! In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

---

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **Work Address:** \_\_\_\_\_

**Email Address:**

May we send you special updates and reminders in your email? \_\_\_ Yes \_\_\_ No

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

May we leave at message at any of the above numbers? ( ) Yes ( ) No

If so, which? ( ) Home ( ) Cell ( ) Work

( ) Female ( ) Male

**Ethnic group:**

- Caucasian  African-American  Asian  
 Hispanic  American Indian  Other \_\_\_\_\_

**Marital status:**

- Single  Married (how long? \_\_\_\_\_)  
 Separated  Divorced (how long? \_\_\_\_\_)  Widowed

**Children:**

Girls \_\_\_\_\_ Boys \_\_\_\_\_

---

Who suggested that you seek consult at North Georgia Family Medicine?

- Self  Referring medical professional  Family  
 Neighbor/friend  The Court

## Past Medical History

Have you been diagnosed with any of the following (currently or in the past)?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Kidney problems           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Seizure disorder    | <input type="checkbox"/> Thyroid problems          | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> High cholesterol          | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Periodontal disease | <input type="checkbox"/> Oral gum/bone problem     | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Whiplash            | <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Cataracts          |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Manic-depressive disorder | <input type="checkbox"/> Other (list below) |

List any other medical conditions you have had (do not include common cold or flu):

*Illnesses*

*Date(s)*

---

---

---

List any previous hospitalizations:

---

---

List known allergies (including medication allergies):

No known allergies

---

List all surgeries (continue on reverse if necessary):

*Procedure*

*Date(s)*

---

---

---

List all injuries (continue on reverse if necessary):

*Injuries*

*Date(s)*

---

---

---

List all prescription medications, over-the-counter medications, vitamins, and supplements that are taking. Continue on reverse if necessary.

*Prescription medication*

*Dosage*

*Prescription medication*

*Dosage*

<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

---

## Family History

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Kidney problems           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Obesity          | <input type="checkbox"/> Depression                | <input type="checkbox"/> Schizophrenia      |
| <input type="checkbox"/> Early senility   | <input type="checkbox"/> Manic-depressive disorder | <input type="checkbox"/> Other (list below) |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Alcoholism                |   |

## Social History

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke now?
<input type="checkbox"/>	<input type="checkbox"/>	Have you smoked in the past? (Year quit: )
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol now?
<input type="checkbox"/>	<input type="checkbox"/>	Did you drink alcohol in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently use street drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Have you used street drugs in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Are you married?
<input type="checkbox"/>	<input type="checkbox"/>	Are you employed? If so, where?
<input type="checkbox"/>	<input type="checkbox"/>	Are you on any type of disability? If so, what for?

---

Signature of person completing the form:  Patient  Other \_\_\_\_\_

## Consent and Insurance Information Form

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date \_\_\_\_\_

Information on patient			
Name (Mr/Mrs/Miss/Dr) _____			
Last name	First name	MI	Nickname _____
			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home address _____			
City _____		State _____	ZIP _____
Home phone _____		Work/Cell phone _____	
Date of birth _____		SS # _____	
Occupation _____			
Previous Physician _____			
Referred by _____		Relationship to referring person _____	

Information on party responsible for payment			
<input type="checkbox"/> Check here if this information is the same as in the box above.			
Home address _____			
City _____		State _____	ZIP _____
Home phone _____		Work phone _____	
Date of birth _____		SS # _____	
Employer _____			
Relationship to patient _____			

Insurance information			
1 <sup>st</sup> insurance company	Policy #	Group #	Insured's name
2nd insurance company	Policy #	Group #	Insured's name

I agree to be responsible for any charges for services and materials supplied by North Georgia Family Medicine and its doctors for the above patient.

\_\_\_\_\_  
Signature of party responsible for payment

\_\_\_\_\_  
Date

---

## Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared the explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and healthcare operations.

**Treatment** means providing, coordinating, or managing your health care and related services by one or more health care providers. An example of this would include a physical examination. It could mean evaluating your problem, like possible bladder infection. It could also mean talking to another doctor who cares for you to discuss your problems or care.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, such as auditing functions.

We may also create and distribute de-identified health information by removing all references to individually identifiable information as required by government agencies. We will disclose information as required by law to the proper agency such as outlined by the laws regarding child abuse, spousal abuse, or commission of a felony. We will report required information on infectious diseases as required by law. **If we suspect that you are committing crimes with your prescriptions, we will notify the appropriate authorities in order to protect others. Activity related to illegal prescription distribution will not be tolerated and will be reported to our local law enforcement agency.**

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office:**

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- **Unless you specifically tell us differently, we will discuss your care with your family. For example, discussing your progress with family if you are hospitalized, or leaving a message about need for medication change or lab result with your family, giving your family or caregivers information about your medications, appointments, or care.**
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For instance, mailing results to a different address.
- The right to inspect and copy your protected health information. Georgia law permits us to charge for copying for your chart.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

### Notice of Privacy Practices Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the North Georgia Family Medicine Notice of Privacy Practices and have had an opportunity to review it. I have also been given an

opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

1. \_\_\_\_\_  
Patient acknowledgement (Signature) Date

### **Consent for Purposes of Treatment, Payment and Health Care Operations**

I understand that, as a condition to my receiving treatment from North Georgia Family Medicine, North Georgia Family Medicine may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of North Georgia Family Medicine. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

“Personally identifiable health information” refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting North Georgia Family Medicine to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request North Georgia Family Medicine to restrict how my health information is used or disclosed. North Georgia Family Medicine does not have to agree to my request for the restriction, but if North Georgia Family Medicine does agree, North Georgia Family Medicine is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that North Georgia Family Medicine has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment maybe withdrawn if I withdraw my consent.

2. \_\_\_\_\_  
Signature Date

**Medicare lifetime consent & Medicaid:** I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

3. \_\_\_\_\_  
Signature Date

..