WEST GEORGIA
internal medicine

West Georgia Internal Medicine P.C.

Patient information Sheet

Confidential Record: Information will not be released unless authorized.

Please fill out completely.

Last Name_____First_____Middle_____

Date of Birth_____ Social Security Number_____

Sex_____MaritalStatus_____Age_____Race_____

Ethnicity_____Language_____Religion_____

Home Phone_____Cell_____Work_____

Address_____

City_____State_____Zip_____

E-mail Address_____

Employer_____

Address_____

Pharmacy Name_____

Location_____Number_____

Insurance Information_____

Spouses or Significant others Name _____Date of Birth_____

Cell_____ Social Security Number_____

Emergency Contact

Name_____Relationship_____

Home_____Cell_____

Allergies_____ Todays Date_____

Signature_____

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Bilingual upon request

DISCLOSURE

PLEASE READ THE FOLLOWING DISCLOSURE CAREFULLY!

All professional services rendered are charged to the patient. We will assist you with insurance reimbursement; however, the patient is responsible for all fees, regardless of insurance coverage. It is our policy to request payment at the time of service, unless arrangements have been made in advance. If you have a question about fees, please check with the receptionist before being seen.

I authorize West Georgia Internal Medicine, P.C., to furnish information to insurance carriers, physicians, or hospitals concerning my illness and treatment. I authorize any physician, hospital, or medical care facility to provide all information on medical history and treatment to West Georgia Internal Medicine, P.C. I assign to West Georgia Internal Medicine, P.C., all insurance payments for medical services including major medical benefits rendered to me. I understand that I am responsible for any amount not covered by assigned insurance. I permit a copy of this authorization to be used in place of the original. I have read all of the above and give West Georgia Internal Medicine, P.C., permission to treat me.

Payment in full, co-payments and/or deductibles, which ever applies, is due at the time services are rendered.

Insurance claims are filed as a courtesy, or as an obligation based on a signed contract with your insurance carrier; however:

Your percentage is due at the time services are rendered
Your deductible must be covered at time of services unless previously met

If your insurance does not pay for their portion after 60 days, you are responsible for the balance, and you will receive a bill for the balance. In the event that your insurance company does not pay in 60 days and you receive a bill from this facility, it is your responsibility to contact your insurance carrier to correct the problem.

This facility does use the services of a Collection Agency; therefore, if payment is not made on a monthly basis, or no payment is made at all, then your account will be placed with a Collection Agency. In the event legal action becomes necessary, you (the patient) will be responsible for all legal fees associated with your account. In the event checks written for services are returned to our office, there will be a $25.00 service charge.

Please sign below to indicate that you have read and understand all of the above statements.

_____ _____

Signature of Patient **Date**

Please visit our web site at www.internalmd.com

Please note a $35.00 no-show fee will apply if appointments are not cancelled with a 24-hour notice of your scheduled appointment time.

West Georgia Internal Medicine
706 Dixie Street, Suite 300
Carrollton, Ga. 30117
Phone: 770-834-6208
Fax: 770-830-7620
Hours of Operation: 8AM- 5PM
After Hours Call: 770-834-6208
If you have an emergency please call 911

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WEST GEORGIA INTERNAL MEDICINE, P.C

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by Letter.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name: _____

Patient/Responsible Party Signature: _____

Date: _____

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WEST GEORGIA INTERNAL MEDICINE

PATIENT CONFIDENTIALITY

Patient Name_____

Date of Birth_____

Patient confidentiality is very important to our clinic. Therefore, it is important for you to provide us with the following information to ensure that there is no violation of your privacy.

In the event that I,_____, am unable to be reached, West Georgia Internal Medicine, may leave test results or other pertinent information with the following:

- ☐ Spouse (name)_____
- ☐ Children (name)_____
- ☐ May leave test results on home answering machine.
- ☐ I may be reached at work (number)_____
- ☐ May leave a message at work on voice mail
- ☐ Other (describe)_____

_____(please initial) In the event that I am unable to be reached, West Georgia Internal Medicine may not leave test results or other information with anyone but myself.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of West Georgia Internal Medicine.

_____ _____

Patient's Signature Date

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NEW PATIENT INFORMATION FORM

Patient_____ Date:_____

DRUG ALLERGIES:_____

HISTORY:

Chief Complaint:_____

History of Present Illness:

Location_____
(where is the pain/problem?)

Severity_____
(How severe is the pain/problem?)

Timing_____
(Does this pain/problem occur at a specific time?)

Duration_____
(How long have you had this pain/problem? or when did it start?)

Associated signs/symptoms_____

_____
(What other associated problems have you been having?)

Modifying Factors:_____
(What makes the pain/problem worse or better? or Have you had any previous episodes?)

MEDICAL HISTORY:

Patient medical history:

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Arthritis/Gout	No	Yes
Seizure Disorder	No	Yes
Liver Disease	No	Yes
Stomach/Colon Disease	No	Yes
Blood Clots	No	Yes
Kidney Disease	No	Yes
Lung Disease/Asthma	No	Yes
Heart Trouble	No	Yes
Thyroid Problems	No	Yes
Cholesterol Elevation	No	Yes

Other:_____
_____
_____

Previous Hospitalizations/surgeries/serious injuries: When?

_____
_____
_____
_____
_____

Medications:

_____
_____
_____
_____
_____
_____

Vaccines: __Flu Yr. Received_____
__Tetanus Yr Received_____
__Pneumonia Yr Received_____
__Hepatitis Yr Received_____

Patient Social History :

Marital status: __Single __Married __Separated __Divorced __Widowed
Use of alcohol: __Never __Rarely __Moderate __Daily
Use of tobacco: __Never __Previously, but quit ___Current pack/day
Use of drugs: __Never If yes, type and frequency:_____
Excessive exposure at home or work to: __Fumes __Dust __Air-borne particles __Pets
Occupation:_____

Family Medical History:

	Age	Disease	If deceased, cause of death and age
Father	___	_____	_____
Mother	___	_____	_____
Brothers	___	_____	_____
	___	_____	_____
Sisters	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____
	___	_____	_____

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SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS:

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES:

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS/NOSE/MOUTH/THROAT:

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR:

Heart trouble	No	Yes
Chest pain or angina	No	Yes
Palpitations/skipping hearbeat	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles, hands	No	Yes

RESPIRATORY:

Chronic or frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL:

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes
Painful bowel movements or constipation	No	Yes
Flexible Sigmoidoscopy	No	Yes

when_____

GENITOURINARY:

Frequent urination	No	Yes
Up at night to urinate	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of stream when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual Difficulty	No	Yes
Male - testicular pain	No	Yes
Male - prostate checked	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female - # pregnancies _____
miscarriages_____
Female - date of last pap smear_____
Female - date of last mammogram_____

Female- hysterectomy	No	Yes

Age at menopause_____

MUSCULOSKELETAL:

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold hands/feet	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (SKIN, BREAST):

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL:

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

PSYCHIATRIC:

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE:

Glandular or hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC:

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC:

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate, or other antiseptic	No	Yes

Other drug/medications_____
_____
Known food allergies_____

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Reason for today's visit:

_____

Have you seen any other physicians since your last visit here? Why?

_____

If female when was your last mammogram? Where?

_____

If female when was your last bone density? Where?

_____

When was your last Pap Smear and what Physician did you see?

_____

Have you received any of the following vaccines? (Please circle yes or no)

Vaccine	Received or Not	Date Received	Pharmacy/Given By
Prevnar 13 (pneumonia vaccine)	YES NO		
Pneumovax (pneumonia booster)	YES NO		
Shingrix (New in 2018) (Shingles vaccine 2 dose)	YES NO		

When was your last colon screening and what physician did you see? Was it normal or were polyps removed? (patients over 50)

_____

If you are 65 and over have you fallen in the past year? (please circle yes or no)

YES NO

Do you have a living will/advanced directive? (please circle yes or no)

YES NO

Do you use tobacco? (smoke, chew, etc) (please circle yes or no)

YES NO

When was your last eye exam and what physician did you see?

_____

Patient email: _____

Preferred Pharmacy: _____

Please note some prescriptions may need prior authorization from your insurance company. We charge $15.00 for prior authorizations. Do you authorize us to complete PA's routinely as requested from your insurance at a $15.00 charge?

YES NO

Has there been a change in address or telephone number? (Please verify contact information on reverse side)
Please circle any medications that need to be refilled on reverse side. 30 day supply or 90 day supply.