**Georgia Family Medicine**
2410 Hog Mountain Rd.
Bldg. 200 Ste. 201
Watkinsville, GA 30677
Phone: 706-310-3470 Fax: 706-310-9526

Please Fill Out Completely: New patient paperwork for minor

| Patient's Last Name | | | | | First Name | | MI |
|---|---|---|---|---|---|---|---|
| Social Security Number | Date of Birth | Age | Gender | Race | Ethnicity (Circle one): Latino Non-Latino Other | Language | |
| Address (Street, Route, Apt. No., etc.) | | | | | City | State | Zip Code |
| Home Phone | Cell Number | | | | Cell phone carrier (ex. Verizon) | | |
| Email Address | | | | | Best way to contact (Circle one): Home Phone Cell Phone Email Letter | | |

## GUARDIAN INFORMATION

| Name | Address | | City | State | Zip Code |
|---|---|---|---|---|---|
| Home Phone | Social Security | Date of Birth | Relationship to Patient | | |
| Employed by | | Business Phone | | | |
| Employer's Address | | | City | State | Zip Code |
| **Emergency Contact** (Friend or relative not at Patient's address who can get a message to you.) | | | | Daytime Phone | |

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: ______________________________

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: ______________________________

______________________________________________________________________________________________

## INSURANCE INFORMATION (Please provide your insurance card(s) at the time of visit)

If your insurance policy holder is different from the guardian information provided above please complete this section.

| Name | Address | | City | State | Zip Code |
|---|---|---|---|---|---|
| Home Phone | Social Security | Date of Birth | Relationship to Patient | | |

**Approved Lab for your Insurance Carrier**: ______________________________________________

______________________________ ______________
Patient or Guardian Signature Date

**GEORGIA FAMILY MEDICINE**
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

## CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

## FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

## ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

**I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.**

**I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.**

**IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.**

| ______________________________ | ______________________ |
|---|---|
| Patient Name (Print) | Patient Date of Birth |
| ______________________________ | ______________________ |
| Guardian Signature | Date |

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Georgia Family Medicine owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor ___________________ to discuss my personal health care information with the following individual(s).

Name/Relationship ________________________________ Phone Number __________________

Name/Relationship ________________________________ Phone Number __________________

Name/Relationship ________________________________ Phone Number __________________

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I understand that this consent may be revoked by me at any time by written notice to our office.

Guardian Signature/Legal Representative: ______________________________ Date: ________________

Reason for Representative: _________________________________________________________________

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

**Consent For Disclosure to Family Member and/or Personal Representative for Georgia Family Medicine and St. Mary's Health Care System, Inc.**

Patient Name __________________________
Address: ______________________________
_____________________________________
Date of Birth: _________________________
SSN# _________________________________
Telephone # ___________________________

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# Authorization for Release of Medical Information

**Patient:** ___________________________________________________ **Date of Birth:** ________________________
(First) (Last)

**I authorize the use or disclosure of the above-named patient's protected health information as described below.**

**I hereby authorize** ____________________________________________________ **to release the information.**

**For the purpose of:** ____________________________________________________________________________

**Check Type of Record to be Released**

☐ Complete Health Record (or check for certain sections)

- ☐ ER Record
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Nursing Documentation
- ☐ Office Notes
- ☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)
- ☐ EKG
- ☐ Chest X-Ray Report
- ☐ Exercise Stress Test Results
- ☐ Echocardiogram Results
- ☐ Nuclear Stress Test Results
- ☐ CT Scan Results
- ☐ Carotid-Vascular Study Results
- ☐ Other as Specified___________ ______________________________

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been released prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

_______________________________________________________ **Date:** _____/______/________
**Patient Signature/Guardian Signature/Legal Representative**

_______________________________________________________ **Date:** _____/______/________
**Printed Name of Guardian/Legal Representative**

**If signed by Legal Representative please provide the following:**
**Relationship to patient:** _________________________________
**Authority to sign on Behalf of the Patient:** ☐ **Custodial Parent** ☐ **Durable Power of Attorney for Healthcare**
☐ **Other, Please describe:** ___________________________________

**Records may be faxed and/or mailed to the fax number and the address provided above.**

## Annual/New Medical History Intake Sheet

Patient Name:______________________________ Birth Date: ____/____/_____ Date:_______________

Describe your main problem today: _________________________________ Allergies: __________________________

Where is your problem located? __________________________________

How severe is your problem? ____________________________________

How long have you had this problem? ______________________________

When does this problem occur? ___________________________________

What other things happen with this problem? _________________________

_______________________________________________________________

List previous hospitalizations/surgeries/serious injuries and when?

_______________________________________________________________

_______________________________________________________________

Date of last immunizations: Tdap ________ Hep B ___________ Hep A ____________

Chicken Pox _________ Meningitis __________ Pneumococcal ______________

Flu ___________

Monthly self breast exam? ☐ No ☐ Yes
Form of regular exercise? ☐ No ☐ Yes _____________
Seat belt use? ☐ No ☐ Yes

*Social History:*

Martial Status: ☐ Single ☐ Married ☐Separated ☐Divorced ☐Widow(ed)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily__________

Use of Tobacco: ☐ Never ☐ Previous but quit ☐ Current packs per day ____
☐ Passive exposure

Use of Drugs: ☐ Never ☐ Type/frequency________________

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

School: _____________________________________ Grade: ______________

Have you ever had the following?

| | | |
|---|---|---|
| Thyroid disease ……………. | yes | no |
| Diabetes ……………........... | yes | no |
| Hypertension ………………. | yes | no |
| Cancer ……........................... | yes | no |
| Stroke ……………………… | yes | no |
| Heart trouble ………………. | yes | no |
| Arthritis or gout …………… | yes | no |
| Convulsions ………………... | yes | no |
| Bleeding Tendency ………... | yes | no |
| Acute infections ……………. | yes | no |
| Sexually transmitted disease … | yes | no |
| Hereditary defects …………… | yes | no |

List medications you are currently taking including nonprescription or herbals

1)____________________________

2)____________________________

3)____________________________

4)____________________________

5)____________________________

6)____________________________

7)____________________________

8)____________________________

9)____________________________

10)___________________________

*Family Medical History:*

| | Age | Disease | If Deceased, cause of death |
|---|---|---|---|
| Father | ____ | ________________________________ | ____________________ |
| Mother | ____ | ________________________________ | ____________________ |
| Siblings | ____ | ________________________________ | ____________________ |
| | ____ | ________________________________ | ____________________ |

Who lives in the home: ☐ Mom ☐ Dad ☐ Grandmother ☐ Grandfather ☐Stepmother ☐ Stepfather
☐ Siblings ☐Other
If other, please explain: ________________________________________

# Georgia Family Medicine

ST. MARY'S MEDICAL GROUP

**Name:** ______________________________________ **Date:** __________________________

**In the last 2 weeks, have you had any of the following symptoms? (Check all that apply, leave blank if not applicable)**

**General:**
- ☐ Fever
- ☐ Chills
- ☐ Change in Appetite
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

**Eyes:**
- ☐ Double or Blurry vision
- ☐ Change in Vision

**ENT:**
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Runny or Congested Nasal Passage
- ☐ Excessive Sneezing
- ☐ Sore Throat
- ☐ Trouble Swallowing
- ☐ Voice Change

**Cardiovascular:**
- ☐ Chest Pain
- ☐ Change of color in Hands/Feet
- ☐ Racing/Skipping Heart Beats
- ☐ Short of breath when walking around
- ☐ Varicose Veins
- ☐ Trouble breathing when laying down at night
- ☐ Dizziness getting out of bed or using the bathroom

**Pulmonary:**
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Excessive Snoring

**Gastrointestinal:**
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Trouble with food "Getting Stuck"
- ☐ Change in bowel habits
- ☐ Black Stools
- ☐ Abdominal Pain

**General Genitourinary:**
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Frequent Urination at night
- ☐ Blood in urine
- ☐ Trouble controlling bladder/Urine leakage
- ☐ Trouble starting urination/Poor urine stream
- ☐ Painful Intercourse
- ☐ Decreased Libido

**Male Genitourinary:**
- ☐ Discharge or Sores
- ☐ Trouble with Erection
- ☐ Testicular Pain

**Female Genitourinary:**
- ☐ Any Discharge or Sores
- ☐ Last Menstrual Cycle Date _______________
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Very Heavy Bleeding
- ☐ Breast Pain
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Currently Breast Feeding
- ☐ Currently Pregnant

**Musculoskeletal:**
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Aches

**Dermatologic:**
- ☐ Rashes
- ☐ Suspicious Lesions/Moles
- ☐ Acne
- ☐ Hair loss/Change in hair
- ☐ Trouble with Fingernails/Toenails

**Neurological:**
- ☐ Headaches
- ☐ Tremors
- ☐ Loss of Balance and/or Falling
- ☐ Numbness or Tingling
- ☐ Feeling Lightheaded or Dizzy
- ☐ Memory Loss

**Psychiatric:**
- ☐ Trouble Concentrating
- ☐ Excessively Stressed
- ☐ Anxious/Irritability
- ☐ Depressed
- ☐ Suicidal
- ☐ Sleeping problems (Insomnia, sleepwalking, nightmares)
- ☐ Seeing/Hearing things that are not there

**Endocrine:**
- ☐ Colder/Hotter than everyone else
- ☐ Excessively Sweating
- ☐ Excessive Hunger or Thirst (more than usual)
- ☐ Constant need to urinate

**Hematological/Lymph:**
- ☐ Frequent nosebleeds
- ☐ Frequent bleeding gums
- ☐ Constant bruising
- ☐ Takes longer to stop bleeding than usual
- ☐ Swollen lymph nodes
- ☐ History of blood transfusions

**Allergy/Immunology:**
- ☐ Food allergies
- ☐ Seasonal Allergies

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# eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Georgia Family Medicine may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

______________________________ ______________________________
Patient Signature (or legal guardian) Print Patient's Name

______________________________ ______________________________
Primary Pharmacy Name Pharmacy Street and City

______________________________
Date

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Dear Patient:

It has come to our attention that there is confusion concerning annual preventive care visits or wellness visits that occur on the same day as a follow-up office visit. Follow-up visits can be for your chronic medical problems and/or new problems or concerns that have arisen since your last appointment here in our office.

- Your annual wellness visit, and/or preventive care visit includes: a review of your overall health and recommended screening procedures (lab tests) and preventive measures (such as vaccinations) that may be beneficial in maintaining overall good health.
- The follow up office visit includes: review of new and/or acute problems or concerns and chronic medical conditions such as hypertension and diabetes.

If you have a new medical problem that needs evaluation and requires your physician to order specific tests and/or medications, this must be billed as a separate office visit. If you have chronic medical conditions that require supervision and surveillance and ordering of specific tests and medications, this is not included in the wellness visit and must be billed as a separate office visit. **As a benefit to you, we offer you the option to have both of these visits done on the same day.** This will prevent you from having to schedule separate exams on separate days.

You can choose to do them on separate visits if you prefer. If you have a health concern, please inform your physician. They will let you know if it will be better to be addressed on the same day as the preventive visit.

If you have any questions concerning this, please ask to speak to the billing staff or the office manager.

I acknowledge receipt of and understanding of this policy.

________________________________ ______________________
Patient Name Patient Date of Birth

________________________________ ______________________
Patient or Guardian Signature Date