

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:

Patient's Last Name					First Name					MI
Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	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					
Employed by										
Business Phone		Employer's Address			City		State	Zip Code		
Person responsible for payment		Relationship to pt	Address					Phone Number		
Insurance Policy Holder Name		DOB	Address					Policy holder SSN		

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent 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)

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

Patient or 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.

Patient signature: _____ Date: _____

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)

- | | | |
|--|---|--|
| <input type="checkbox"/> ER Record | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Echocardiogram Results |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Most Recent Lab Work
(BMP, CMP, Lipids, LFTs) | <input type="checkbox"/> Nuclear Stress Test Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG | <input type="checkbox"/> CT Scan Results |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Chest X-Ray Report | <input type="checkbox"/> Carotid-Vascular Study
Results |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Exercise Stress Test Results _____ | <input type="checkbox"/> Other as
Specified _____ |
| <input type="checkbox"/> Nursing Documentation | | |

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 release 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.

Patient Signature **Date:** ____/____/____

Printed Name of Legal Representative **Date:** ____/____/____

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.



Georgia Family Medicine

ST. MARY'S MEDICAL GROUP

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: Mammogram _____

Colonoscopy _____

Pneumovax _____

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

Social History:

Marital 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 ____

Use of Drugs: Never Type/frequency _____

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

Occupation: _____

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	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

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 Patients Name

Primary Pharmacy Name

Pharmacy Street and City

Secondary Pharmacy if applicable

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 and/or annual Medicare 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 (such as mammograms, colonoscopies and certain lab tests) and preventive measures (such as vaccinations) that may be beneficial in maintaining overall good health.
- The 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