ST. MARY'S MEDICAL GROUP

Patient Registration Forms **Please Fill out Completely**

Date:	Are you a patient of any other St. Mary's Medical Group location? YES NO If yes, what other locations?	Name of Physician you are scheduled to see

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	Do any other family members use this email address? List names	Best way to contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Letter

EMPLOYER INFORMATION

Employed by	Occupation

Business Phone	Employer's Address	City	State	Zip Code

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

Name	Relationship to patient	Responsible for bill: YES NO

Home Phone	Social Security	Date of Birth	Sex

Employed by	Business Phone

Employer's Address	City	State	Zip Code

EMERGENCY CONTACT

Name	Relationship	Home Phone	Work Phone	Mobile Phone

PHYSICIAN INFORMATION

Complete this section only if applicable

Primary Care Physician Name	Phone		
Address	**City**	**State**	**Zip Code**
Referring Physician Name	**Phone**		
Address	**City**	**State**	**Zip Code**

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

Primary Insurance Name	Subscriber Name	Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO
Secondary Insurance Name	**Subscriber Name**	**Date of Birth**	**Social Security #**	**Relationship to patient**	**Responsible for bill:** **YES NO**

_____ _____

Patient or Guardian Signature Date

ST. MARY'S
MEDICAL GROUP

ST. MARY'S HEALTH CARE SYSTEM, INC. ("SMMG") CONSENT/AUTHORIZATIONS

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 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 St. Mary's Health Care System, Inc.

Patient Name _____

Address: _____

_____

Date of Birth: _____

ST. MARY'S MEDICAL GROUP

Authorization for Release of Medical Information

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

Patient Name		Date of Birth	Last 4 digits of SSN
Address	City	State	Zip

Please circle: I authorize St. Mary's Medical group to <u>OBTAIN or RELEASE</u> records from:
Name/Organization

Address	Phone	Fax

Please send records to:
Name/Organization

Address	Phone	Fax

If records are to be released from SMMG, please indicate which location. Check all that apply.

☐ **Athens Internal Medicine Associates**	☐ **Athens General and Colorectal Surgeons**
☐ **Community Medicine of Athens**	☐ **Clear Creek OBGYN**
☐ **Georgia Family Medicine**	☐ **Endocrine Specialists of Athens**
☐ **Johnson and Murthy Family Practice**	☐ **Infectious Disease Specialists of Athens**
☐ **Lighthouse Family Practice**	☐ **Northeast Cardiology**
☐ **Middle GA Medical Associates**	☐ **Oconee Heart and Vascular Center**
☐ **St. Mary's Internal Medicine Associates**	☐ **Rheumatology Center of Athens**
☐ **Hometown Pediatrics**	☐ **St. Mary's Neurological Specialists**

Purpose of Release? ☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal
☐ Other _____

What type of records/reports should be released?

☐ Complete Record	☐ Most recent lab work	☐ Mammogram
☐ ER Record	☐ Echo	☐ CT Scan _____
☐ Office Notes	☐ Nuclear Stress Test	☐ MRI _____
☐ History and Physical	☐ Exercise Stress Test	☐ EEG
☐ Discharge Summary	☐ EKG	☐ EMG/NCS
☐ Consultation Report	☐ Carotid/Vascular Study	☐ Other:_____
☐ Surgical/Operative Report	☐ Chest X-Ray	

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.

_____ **Date: _____/_____/_____**

Patient Signature/Legal Representative Signature

_____ _____

Printed Name of Legal Representative **Relationship to patient**

ST. MARY'S MEDICAL GROUP

St. Mary's Medical Group
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 St. Mary's Medical Group 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

ST. MARY'S MEDICAL GROUP

Medical History

Please take a few minutes to fill out our health history forms. Please fill in all areas, before your appointment. Your answers will help our providers plan for your visit and provide you the best care.

Name: _____ Date of Birth: _____ Today's Date: _____

Pharmacy: _____ Location: _____

Reason for visit/main problem: _____ Where is your problem located: _____

How long have you had this problem: _____ What makes it worse or better: _____

_____

ADVANCE DIRECTIVES: *Please check all that apply*

Do you have a Power of Attorney for health care? ☐ No ☐ Yes Designated Individual:

Do you have a living will/Do Not Resuscitate? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PATIENT CARE TEAM: *Please answer each question*

Specialty:	Name/Group:	Last Visit Date:	Specialty:	Name/Group:	Last Visit Date:
Cardiologist			OBGYN		
Neurologist			Eye Doctor		
Surgeon			Pulmonologist		
Dermatologist					
Gastro					

CURRENT MEDICAL HISTORY: *Please check all that apply*

☐ Addiction
☐ Anemia
☐ Anxiety
☐ Arthritis/Gout
☐ Asthma
☐ Bipolar
☐ Colon Disease
☐ Congestive Heart Failure
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes
☐ Enlarged Prostate
☐ Reflux/GERD
☐ Blood Clot
☐ Heart Attack

☐ Hepatitis type: _____
☐ High Cholesterol
☐ High Blood Pressure
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Migraines
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pulmonary Embolism
☐ Schizophrenia
☐ Skin Disease
☐ Stroke
☐ Thyroid Disease

Are you currently under treatment/s for Cancer?
☐ No ☐ Yes Type: _____
_____
_____

Other Mental Illness: _____
_____
_____

Other Illness: _____
_____
_____
_____
_____

Have you fallen in the last 2 months? ☐ No ☐ Yes

Have you fallen in the last 6 months? ☐ No ☐ Yes

HOSPITALIZATIONS/SURGERIES: *Please check all that apply*

☐ Appendectomy
☐ Coronary Artery Bypass (Open Heart)
☐ Carotid Endarterectomy
☐ Cholecystectomy (Gallbladder)
☐ Bariatric Type: _____

☐ Hysterectomy
☐ Mastectomy
☐ Nephrectomy
☐ Splenectomy
☐ Tonsillectomy/Adenoidectomy

☐ Other surgeries: _____
_____
☐ Other Hospitalizations: _____
_____
_____

FAMILY MEDICAL HISTORY: *Please check all that apply and check all family members that apply*

Illness	Relation to you
☐ Alcoholism	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Anemia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Asthma	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Blood Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Cancer Type: _____	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent

Illness	Relation to you
☐ Stroke	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Dementia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Diabetes	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Heart Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ High Cholesterol	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ High Blood Pressure	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Kidney Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Mental Illness	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Osteoporosis	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Heart Attack <50 yrs of age	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Seizures/Epilepsy	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Thyroid Problems	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Other: _____	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent

SOCIAL HISTORY: *Please check and/or answer each question.*

Tobacco Use	☐ Current Packs/day: _____ ☐ Former Year Quit: _____ ☐ Never ☐ Exposure second hand ☐ E-Cigs ☐ Smokeless ☐ Other: _____
Alcohol Use	☐ Never drink ☐ Occasional/social drinker ☐ _____# of drinks/day of alcohol
Drug Use	☐ None ☐ Other use:
Caffeine Use	☐ No ☐ Yes How Much: _____
Exercise	Regular Exercise? ☐ No ☐Yes ☐Sedentary ☐Light ☐Moderate
Seatbelt use	☐ No ☐ Yes
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single # of Children: _____ # of Grandchildren: _____ Spouse's Name: _____
Living Arrangements	☐ Independent ☐ Alone ☐ With others ☐ Homeless ☐ Nursing Home ☐ Assisted Living ☐ With Caregivers
Employment	Occupation: _____ Employer: _____
Sexually Active	☐ No ☐ Yes with: ☐ Male ☐ Female ☐ Both # of sexual partners: _____
Environment exposures	☐ Fumes ☐ Dust ☐ Solvents ☐ Noise ☐ Bloodborne Pathogens ☐ Other: _____

WOMENS HEALTH HISTORY: *Check and/or answer each question.*

Age at first period: _____ yrs old	Has menopause started/occurred? ☐ No ☐ Yes at age _____ yrs
Number of days between periods: _____	Number of days period lasts: _____ Flow is: ☐ light ☐ moderate ☐ heavy
Number of: Total Pregnancies: _____	Full term births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____
Number of: Vaginal births: _____ C-Section: _____	Pregnancy Complications: ☐ No ☐ Yes ☐ High BP ☐ Diabetes ☐ Pre-eclampsia ☐ other: _____

Birth Control: ☐ None ☐ Pill ☐ Depo-Provera ☐ IUD ☐ Partner-Vasectomy ☐ Tubal Ligation ☐ Other: _____

ALLERGIES: *List all allergies and the type of reaction*

Allergy	Reaction

CURRENT MEDICATIONS: *List all medications including over the counter and supplements. Please bring your medicine bottles to your appointment. Please attach a second sheet if more space is needed.*

Medicine	Dosage	Taken How often	Provider	Need Refill?
Example: Lasix	20mg	Twice a day	Dr. Smith	Yes

IMMUNIZATIONS: *Please check all that apply* ****Please bring a copy of your immunization records to your appointment****

Vaccine	Administered Date	Vaccine	Administered Date
Tetanus		Shingles	
Pneumonia		HPV	
Flu Shot		Meningitis	
Hep B		Hep A	

PREVENTIVE CARE: *Please list the dates of your last test, facility test was performed and the results if known.*

Test	Date	Facility	Results
Mammogram			
Pap Smear			
Colonoscopy			
Hemoccult			
Dexa/Bone Density			
PSA			

DEPRESSION SCREENING: *Please answer both questions.*

Over the past two weeks, I have had little interest or pleasure in doing things: ☐ No ☐ Yes

Over the past two weeks, I have felt down, depressed or hopeless: ☐ No ☐ Yes

Do you have a past history of depression? ☐ No ☐ Yes Are you currently being treated for depression? ☐ No ☐ Yes

REVIEW OF SYSTEMS: *Check all symptoms below that you are CURRENTLY experiencing.*

General
- ☐ Fever
- ☐ Chills
- ☐ Change in Appetite
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

Eyes
- ☐ Double vision
- ☐ Blurred Vision
- ☐ Change in vision

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches

Dermatologic
- ☐ Suspicious lesions
- ☐ Itching
- ☐ Rash

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep problems

ENT
- ☐ Ear Pain
- ☐ Decreased Hearing
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Voice change
- ☐ Sinus problems

Cardiovascular
- ☐ Chest pain
- ☐ Racing/skipping beats
- ☐ Swelling (feet/legs/hands)
- ☐ Leg pain with exertion
- ☐ Varicose veins

Hematological
- ☐ Enlarged lymph nodes
- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Anemia

Allergy
- ☐ Hives
- ☐ Rash
- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Year round allergies

Respiratory
- ☐ Sleep disturbance due to breathing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Excessive snoring

Female Genitourinary
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Pain with periods
- ☐ Irregular periods
- ☐ Vaginal discharge

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Frequent urination at night
- ☐ Incontinence
- ☐ Decreased libido

Male Genitourinary
- ☐ Erectile dysfunction
- ☐ Testicular pain

Gastrointestinal
- ☐ Indigestion/heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Dark tarry stools
- ☐ Bloody stools

Neurological
- ☐ Difficulty concentrating
- ☐ Headaches
- ☐ Falling down
- ☐ Weakness
- ☐ Tremors
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Lightheadedness
- ☐ Vertigo

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive urination
- ☐ Excessive thirst

Additional information you would like to share with the provider: