



# Georgia Infectious Diseases, PC

5673 Peachtree Dunwoody Rd NE, Suite 600 · Atlanta, Georgia 30342

Phone: (404) 256-4111 · Fax: (404) 256-0040

## PATIENT INFORMATION FORM

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: F / M / T

Address: \_\_\_\_\_  
*Street Address* *Apt/Unit #* *Zip Code*

Preferred Phone Number: \_\_\_\_\_  Cell  Home  Home OK to leave medical information on voice mail?  
 Yes  No

Secondary Phone Number: \_\_\_\_\_  Cell  Home

Email Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
*Name* *Relationship* *Phone Number*

### Insurance Information

Type of Insurance:  Commercial  Medicare  Medicaid  Worker's Comp  Self Pay

Primary Insurer: \_\_\_\_\_ Secondary Insurer: \_\_\_\_\_

Does your insurer require a referral to be seen at a specialty practice?  Yes  No

**PLEASE HAND YOUR INSURANCE CARD AND PHOTO ID CARD TO THE RECEPTIONIST.**

\*\*\*\*\*

**By signing below, I attest that the above information is correct to the best of my knowledge.**

\_\_\_\_\_  
Signature of Patient or Legal Surrogate \_\_\_\_\_ Date \_\_\_\_\_ Time

\_\_\_\_\_  
Printed Name of Patient or Legal Surrogate \_\_\_\_\_ Relationship (If Legal Surrogate)

## NEW PATIENT HEALTH HISTORY

Please take a moment to provide your most up-to-date health information. We will upload your responses below, along with the information contained in the medical records sent to us, to your medical chart to ensure we have your most complete medical history. If you have other medical conditions that are not listed in the options below, please tell them to your medical assistant.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Additional Complaint(s): \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Weight: \_\_\_\_\_ pounds

### PAST MEDICAL HISTORY

#### Cardiovascular

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Mitral valve disease        |
| <input type="checkbox"/> Aortic valve disease     | <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Atrial fibrillation      | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Pulmonary embolism          |
| <input type="checkbox"/> Cardiomyopathy           | <input type="checkbox"/> Lower extremity edema   | <input type="checkbox"/> Rheumatic fever             |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Lymphedema              | <input type="checkbox"/> Venous insufficiency        |

#### Respiratory

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Cystic fibrosis           | <input type="checkbox"/> Pulmonary fibrosis           |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Pulmonary hypertension       |
| <input type="checkbox"/> Bronchiectasis    | <input type="checkbox"/> Interstitial lung disease | <input type="checkbox"/> Respiratory failure, chronic |
| <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Lung cancer               | <input type="checkbox"/> Sarcoidosis                  |
| <input type="checkbox"/> COPD              | <input type="checkbox"/> Obstructive sleep apnea   | <input type="checkbox"/> Sinusitis, chronic           |

#### Dermatology

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Psoriasis            | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Hidradenitis suppurativa | <input type="checkbox"/> Pyoderma gangrenosum | <input type="checkbox"/> Skin cancer |

#### Endocrine

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adrenal disorder  | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Polycystic ovarian syndrome |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Hypothyroidism  | <input type="checkbox"/> Thyroid cancer              |

#### Gastroenterology

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Celiac disease    | <input type="checkbox"/> Gallstones               | <input type="checkbox"/> Liver cancer       |
| <input type="checkbox"/> Cirrhosis         | <input type="checkbox"/> GERD                     | <input type="checkbox"/> Pancreatic cancer  |
| <input type="checkbox"/> Colon cancer      | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Pancreatitis       |
| <input type="checkbox"/> Crohns disease    | <input type="checkbox"/> Hemorrhoid               | <input type="checkbox"/> Stomach cancer     |
| <input type="checkbox"/> Diverticulitis    | <input type="checkbox"/> Hiatal Hernia            | <input type="checkbox"/> Stomach ulcer      |
| <input type="checkbox"/> Esophageal cancer | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcerative colitis |

## **PAST MEDICAL HISTORY (continued)**

### **Genitourinary**

- Bladder cancer
- Prostate cancer
- Urinary incontinence
- Erectile dysfunction
- Testosterone deficiency
- Urinary retention

### **Gynecology**

- Cervical cancer
- Fibroids
- Ovarian cancer
- Endometriosis
- Leiomyosarcoma
- Uterine cancer

### **Hematology/Oncology**

- Anemia
- Clotting disorder
- Multiple myeloma
- Bleeding disorder
- Hemochromatosis
- Myelodysplastic syndrome
- Breast cancer
- Leukemia
- Sickle cell disease
- Chemotherapy
- Lymphoma

### **Infectious Disease/Immunology**

- Abscesses, recurrent
- Frequent UTI
- Hypogammaglobulinemia
- Aspergillosis
- Genital warts
- Immunosuppressive therapy
- Breast infection
- Gonorrhea
- MRSA infection
- Chlamydia
- Hepatitis B
- Pelvic inflammatory disease
- Chronic sinusitis
- Hepatitis C
- Postoperative infection
- CVID
- Herpes simplex, oral
- Shingles
- Diabetic foot infection
- Herpes simplex, genital
- Stem cell transplant
- Endocarditis
- HIV
- Syphilis
- Frequent pneumonia
- Human papilloma virus (HPV)
- Tuberculosis

### **Musculoskeletal**

- Charcot foot
- Hip fracture
- Osteoporosis
- Chronic low back pain
- Muscular dystrophy
- Scoliosis
- Gout
- Osteoarthritis
- Spinal stenosis

### **Nephrology**

- Chronic kidney disease
- Kidney cancer
- Polycystic kidney disease
- Dialysis
- Kidney stone
- Solitary kidney
- Glomerulonephritis
- Lupus nephritis

### **Neurologic**

- Aneurysm, cerebral
- Hydrocephalus
- Parkinsons disease
- Dementia
- Migraine headache
- Seizure disorder
- Essential tremor
- Multiple sclerosis
- Stroke
- Guillain-Barre syndrome
- Paralysis
- Subdural hematoma

### **Psychiatry**

- Alcoholism
- Bipolar disorder
- Fibromyalgia
- Anxiety
- Chronic fatigue syndrome
- Insomnia
- Attention deficit (ADHD)
- Depression
- Schizophrenia

### **Rheumatology**

- Ankylosing spondylitis
- Lupus
- Sjogrens disease
- Granulomatosis with polyangiitis
- Raynauds disease
- Temporal arteritis
- Rheumatoid arthritis
- Vasculitis

**PAST SURGICAL HISTORY**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AICD (defibrillator)   | <input type="checkbox"/> Dialysis catheter       | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Appendectomy           | <input type="checkbox"/> Gastric bypass/sleeve   | <input type="checkbox"/> Port catheter              |
| <input type="checkbox"/> Arteriovenous fistula  | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Shoulder replacement       |
| <input type="checkbox"/> Arteriovenous graft    | <input type="checkbox"/> Hip replacement         | <input type="checkbox"/> Spine surgery              |
| <input type="checkbox"/> Breast surgery         | <input type="checkbox"/> Hysterectomy            | <input type="checkbox"/> Splenectomy                |
| <input type="checkbox"/> Cholecystectomy        | <input type="checkbox"/> Knee replacement        | <input type="checkbox"/> Tonsillectomy              |
| <input type="checkbox"/> Coronary bypass (CABG) | <input type="checkbox"/> Organ transplant        | <input type="checkbox"/> Ventriculoperitoneal shunt |

**FAMILY HISTORY**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Sarcoidosis         |
| <input type="checkbox"/> Aortic aneurysm      | <input type="checkbox"/> Hypertension              | <input type="checkbox"/> Seizure disorder    |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Immune deficiency         | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Bleeding disorder    | <input type="checkbox"/> Kidney disease            | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Lung disease              | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Clotting disorder    | <input type="checkbox"/> Lupus                     | <input type="checkbox"/> Ulcerative colitis  |
| <input type="checkbox"/> Crohns disease       | <input type="checkbox"/> Polycystic kidney disease | <input type="checkbox"/> I was adopted       |
| <input type="checkbox"/> Diabetes mellitus    | <input type="checkbox"/> Psoriasis                 |  |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Rheumatoid arthritis      |  |

**SOCIAL HISTORY**

- Alcohol:**       None     Rare     Occasional     Regularly
- Tobacco:**      None     Rare     Occasional     Regularly
- Recreational drug:**     None     Rare     Occasional     Regularly    (Type: \_\_\_\_\_)
- Exercise:**       None     Rare     Occasional     Regularly

**Occupation:** \_\_\_\_\_     Active     Not working     Retired     Disabled

**Partnership status:**     Single     Married/Partnered     Divorced     Widowed

\*\*\*\*\*

By signing below, I attest that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Legal Surrogate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name of Patient or Legal Surrogate

\_\_\_\_\_  
Relationship (If Legal Surrogate)

## CURRENT MEDICATIONS FORM

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Current Medications

We encourage you to bring your medications to the office with you so that we can review your medications and enter them into the medical record. Or, if you prefer, bring in a list of your medications, or complete this form ahead of time, and hand it to your medical assistant when you arrive for your office visit.

I take no medications

<i>Medication Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Reason</i>

### Medication Allergies

I have no known medication allergies

<i>Medication Name</i>	<i>What was the reaction?</i>	<i>How long ago did this happen?</i>

## CONSENT TO COMMUNICATE HEALTH INFORMATION

As a patient, you may designate a partner, family member, friend, or other persons with who Georgia Infectious Diseases, P.C. can communicate about your health care status. This form is not required in all circumstances for your doctor or others at Georgia Infectious Diseases, P.C. to be able to communicate with your family about your health care. However, by designating on this form certain individuals who you want to be informed about your care, you can ensure that your provider can communicate without delay with the person(s) you designate below.

I, \_\_\_\_\_, hereby consent to have my health information and care discussed with the following individual(s):

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>
<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>
<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>

I understand that this consent can be revoked by submitting a written request to Georgia Infectious Diseases, P.C. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. This consent shall remain in effect until such time as I revoke it in writing.

**By signing below I indicate that I have read and understood the policy described above.**

<b>Signature of Patient or Legal Surrogate</b>	<b>Date</b>	<b>Time</b>
<b>Printed Name of Patient or Legal Surrogate</b>	<b>Relationship (If Legal Surrogate)</b>	

## APPOINTMENT POLICIES AND FINANCIAL RESPONSIBILITY AGREEMENT

### **Appointment Policies**

Our administrative office hours are Monday through Friday from 8:00am until 4:30pm. Clinic hours vary by provider but are generally four half-days each week. We make every effort to schedule your appointment at the most convenient time for you. If you cannot keep your appointment, please let us know of your cancellation as soon as possible so that we may offer the slot to another patient.

A \$35.00 fee will be applied to all missed appointments or late cancellations (appointments cancelled within 24 hours of the scheduled time). To help remind you of your upcoming appointment, we will send out reminders via text or email. If need be, you will have the opportunity to cancel your appointment by replying to any of these reminder messages.

Please bring your insurance card and a photo ID to every visit. Please also include proof of a physical address (i.e.: no "P.O. Box" addresses allowed).

### **Insurance and Associated Fees**

We must collect all fees and co-payments that your insurance may require at the time of your visit – this is a contractual obligation we have with the insurance companies and these fees cannot be waived. Please make every effort to make sure we are in-network with your specific insurance plan. If we do not participate with your insurance plan, you must make full payment for all services rendered at the time of your visit. In those cases, as a courtesy, we will still try to file a claim on your behalf, though your insurance carrier may or may not reimburse you according to its practices and policies.

If your insurer requires a pre-authorization for you to see one of our providers, then you are responsible for obtaining that referral or authorization from your primary care physician. We will assist as able, but if an authorization is required and not obtained, then you will be responsible for the full payment of the visit and any associated service fees.

We are considered to be a third party with your insurance company. Please understand that the Explanation of Benefits that we receive from your insurer is how we apply any payment or deductible to your account. We are not responsible for any discrepancies with your insurance company. We will help provide any necessary medical records (from our physicians) if you need to file an appeal with your insurer.

### **Delinquencies and Other Fees**

After 120 days, any delinquent debts will be referred to an outside collections agency, at which time they will assume full responsibility for your account. If it looks like you will be unable to fulfill your debt within 120 days, please contact our office immediately so that we can help set up a payment plan or make other arrangements.

Returned checks are subject to a \$35.00 NSF charge. This fee is assessed to us by our bank which we then forward on to you. There is a \$50.00 fee for faxing or mailing any forms up to 5 pages each, additional pages are \$2.00 each. This fee must be paid in advance of documents being released. This fee is waived for documents requested specifically by another provider's office or healthcare setting.

**By signing below I indicate that I have read and understood the policies described above.**

\_\_\_\_\_  
Signature of Patient or Legal Surrogate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name of Patient or Legal Surrogate

\_\_\_\_\_  
Relationship (If Legal Surrogate)

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT OF BENEFITS

I HEREBY AUTHORIZE the release of any medical information, including information related to psychiatric care, drug and alcohol use, HIV/AIDS status, or other confidential information, as necessary to process insurance claims, or any other medical information that is required for any healthcare-related utilization review or quality assurance activities.

I hereby assign and authorize payment to Georgia Infectious Diseases, P.C. of all medical and surgical benefits, including major medical benefits, to which I am entitled under any health insurance policy, self-insurance program, or other medical benefit plan.

**I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to Georgia Infectious Diseases, P.C. by any insurance policy, self-insurance program, or other medical benefit plan.**

This authorization shall remain valid during my care at Georgia Infectious Diseases, P.C. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

**By signing below I indicate that I have read and understood the policies described above.**

\_\_\_\_\_  
Signature of Patient or Legal Surrogate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name of Patient or Legal Surrogate

\_\_\_\_\_  
Relationship (If Legal Surrogate)

## ACKNOWLEDGEMENT OF HIPAA PATIENT PRIVACY POLICY

I acknowledge that a copy of the office HIPAA patient privacy policy was made available to me and that I had ample time to review the document and ask questions. I also acknowledge that printed copies of this policy are available upon request. I understand that any questions or concerns I have about the privacy policy should be directed to the practice administrator.

\_\_\_\_\_  
Signature of Patient or Legal Surrogate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name of Patient or Legal Surrogate

\_\_\_\_\_  
Relationship (If Legal Surrogate)