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 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.

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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)**

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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

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MEDICAL HISTORY – Please tell us if a doctor or hospital has given you any of the following medical diagnoses:

Breast
- ☐ Breast abscess
- ☐ Breast cancer
- ☐ Breast implant complication
- ☐ Inflammatory breast disorder

Cardiovascular (Heart/Vessels)
- ☐ Aortic aneurysm
- ☐ Atrial fibrillation
- ☐ Cardiomyopathy
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Endocarditis
- ☐ Hypertension
- ☐ Lymphedema
- ☐ Peripheral vascular disease
- ☐ Rheumatic fever
- ☐ Valvular heart disease
- ☐ Venous insufficiency

Dermatologic (Skin)
- ☐ Eczema
- ☐ Hidradenitis suppurativa
- ☐ Psoriasis
- ☐ Shingles (Zoster)
- ☐ Skin abscess
- ☐ Skin cancer

Endocrine (Hormonal)
- ☐ Diabetes mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Polycystic ovarian syndrome
- ☐ Thyroid cancer

Gastrointestinal
- ☐ Cirrhosis of liver
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Esophageal reflux (GERD)
- ☐ Pancreatic cancer
- ☐ Peptic ulcer
- ☐ Ulcerative colitis

Gynecologic
- ☐ Cervical cancer
- ☐ Endometriosis
- ☐ Leiomyosarcoma
- ☐ Ovarian cancer
- ☐ Ovarian cyst

Hematologic (Blood)
- ☐ Anemia
- ☐ Anticoagulants, long term
- ☐ Asplenia (no spleen)
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Myelodysplastic syndrome (MDS)
- ☐ Sickle cell anemia

Infectious/Immunologic
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Hepatitis B virus
- ☐ Hepatitis C virus
- ☐ Herpes simplex, genital
- ☐ Herpes simplex, oral
- ☐ HIV
- ☐ HPV (Human papilloma virus)
- ☐ Immunodeficiency state
- ☐ MRSA
- ☐ Syphilis
- ☐ Tuberculosis

Kidney/Renal
- ☐ Chronic kidney disease
- ☐ ESRD on dialysis
- ☐ Kidney cancer
- ☐ Kidney stone (nephrolithiasis)
- ☐ Kidney transplant status
- ☐ Lupus nephritis
- ☐ Polycystic kidney
- ☐ Solitary kidney

MEDICAL HISTORY (continued)

Musculoskeletal (Bone/Joint)
- ☐ Carpal tunnel syndrome
- ☐ Diabetic foot infection
- ☐ Gout
- ☐ Hip fracture
- ☐ Low back pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Spinal stenosis
- ☐ Tendon rupture

Neurologic (Brain/Nervous system)
- ☐ Dementia
- ☐ Epilepsy (seizures)
- ☐ Meningitis
- ☐ Migraine headache
- ☐ Parkinson's disease
- ☐ Stroke

Psychiatric
- ☐ Alcoholism
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Chronic fatigue syndrome
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Schizophrenia

Respiratory (Lung/Airway)
- ☐ Allergic rhinitis
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Interstitial lung disease
- ☐ Lung cancer
- ☐ Pulmonary embolism
- ☐ Pulmonary fibrosis
- ☐ Sinusitis, chronic

Rheumatologic (Autoimmune)
- ☐ Rheumatoid arthritis
- ☐ Sarcoidosis
- ☐ SLE (Lupus)
- ☐ Vasculitis

Urologic (Bladder/Prostate)
- ☐ BPH (enlarged prostate)
- ☐ Bladder cancer
- ☐ Prostate cancer
- ☐ Urinary incontinence
- ☐ Urinary retention
- ☐ UTIs, recurrent

SURGICAL HISTORY – Please tell us if you have had any of the following surgical procedures:

- ☐ AICD (defibrillator)
- ☐ Appendectomy
- ☐ Arteriovenous fistula
- ☐ Arteriovenous graft
- ☐ Breast surgery
- ☐ Cholecystectomy (Gallbladder)
- ☐ Coronary bypass (CABG)
- ☐ Dialysis catheter
- ☐ Gastric bypass/sleeve
- ☐ Heart valve replacement
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Organ transplant
- ☐ Pacemaker
- ☐ Port catheter
- ☐ Shoulder replacement
- ☐ Spine surgery
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Ventriculoperitoneal shunt

FAMILY HISTORY – Please tell us if any of the following medical problems occur in your immediate family.

- ☐ No major medical problems
- ☐ I was adopted
- ☐ Aortic aneurysm
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast cancer
- ☐ Chronic kidney disease
- ☐ Colon cancer
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Diabetes mellitus
- ☐ Hypertension
- ☐ Immunodeficiency disorder
- ☐ Lung cancer
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Sarcoidosis
- ☐ SLE (Lupus)
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcerative colitis

SOCIAL HISTORY – Please tell us briefly about your habits, work, and partnership status.

Alcohol: ☐ 3 or more drinks/day ☐ 2 or less drinks/day ☐ Past alcohol ☐ Never/Rare alcohol

Tobacco: ☐ Every day ☐ Some days ☐ Former smoker ☐ Never smoker ☐ Smokeless tobacco

Recreational drugs: ☐ Never ☐ Past Use ☐ Recent/Ongoing use ☐ Recovering addict

Exercise (weekly): ☐ Light ☐ Moderate ☐ Vigorous ☐ Rare or None

Occupation: _____ ☐ Full time ☐ Part time ☐ Unemployed ☐ Disability ☐ Retired

Partnership status: ☐ Single ☐ Living w/partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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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

Medication Name	*Dose*	*Frequency*	*Reason*

Medication Allergies

☐ I have no known medication allergies

Medication Name	*What was the reaction?*	*How long ago did this happen?*

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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):

_____	_____	_____
Name	*Relationship*	*Phone Number*
_____	_____	_____
Name	*Relationship*	*Phone Number*
_____	_____	_____
Name	*Relationship*	*Phone Number*

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.

_____	_____
Signature of Patient or Legal Surrogate	**Date** **Time**
_____	_____
Printed Name of Patient or Legal Surrogate	**Relationship (If Legal Surrogate)**

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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, including a pre-payment toward any unmet deductible – 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 insufficient funds charge. This fee is assessed to us by our bank which we then forward on to you.

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)**

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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)**