

NORTHEAST GEORGIA SURGICAL CONSULTANTS, P.C.

PATIENT NAME: _____	D.O.B. _____	PHARMACY: _____	TODAY'S DATE: _____
		PHONE #: _____	

MEDICAL HISTORY

	YES	NO
HIGH BLOOD PRESSURE		
DIABETES		
HEART DISEASE		
IRREGULAR HEARTBEAT		
ANGINA/ LEFT SIDED CHEST PAIN		
CONGESTIVE HEART FAILURE		
HEART ATTACK		
STROKE		
VASCULAR DISEASE		
HARDENING OF THE ARTERIES		

	YES	NO
LUNG DISEASE		
ASTHMA/EMPHYSEMA		
PNEUMONIA/BRONCHITIS		
LIVER DISEASE/HEPATITIS		
OTHER INFECTIOUS DISEASE		
KIDNEY DISEASE		
THYROID DISORDER		
OTHER ENDOCRINE SYSTEM DISORDER		
CANCER		
AIDS OR RISK FACTORS (HOMOSEXUAL CONTACTS, BLOOD TRANSFUSIONS 1975-1985)		

PLEASE INDICATE ANY SURGERY YOU HAVE UNDERGONE (APPROXIMATE DATE, AND THE NAME OF YOUR SURGEON)

	DATE	SURGEON		DATE	SURGEON
APPENDECTOMY	_____	_____	MASTECTOMY	_____	_____
BREAST BIOPSY	_____	_____	THYROID SURGERY	_____	_____
COLON SURGERY	_____	_____	HERNIA REPAIR	_____	_____
GALLBLADDER	_____	_____	ENDOSCOPY	_____	_____
HEMORRHOID	_____	_____	OTHER:	_____	_____
BOWEL OBSTRUCTION	_____	_____		_____	_____
HYSTERECTOMY	_____	_____		_____	_____

CURRENT MEDICATIONS (INCLUDING PRESCRIPTION, OVER THE COUNTER MEDICINES, AND CONTRACEPTIVES)

NAME	AMOUNT/DOSAGE	HOW OFTEN	LAST DOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ANY ALLERGIES: _____ REACTION: _____

DO YOU HAVE ANY PROBLEMS OR MEDICAL CONDITIONS NOT COVERED BY THE ABOVE QUESTIONS? IF SO PLEASE EXPLAIN.

DO YOU SMOKE CIGARETTES?	Y	N	IF YES, NUMBER OF PACKS PER DAY
DO YOU USE OTHER TOBACCO PRODUCTS?	Y	N	IF SO, WHAT?
DO YOU DRINK ALOCHOL	Y	N	AMOUNT PER DAY/PER WEEK
DO YOU USE ILLICIT DRUGS	Y	N	TYPE ANY IV DRUG USE?

HAVE ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAD

HYPERTENSION	Y	N	BLEEDING DISORDERS	Y	N
DIABETES	Y	N	SICKLE CELL DISEASE	Y	N
HEART ATTACK<60 YEARS OLD	Y	N	BREAST CANCER	Y	N
STROKE<60 YEARS OLD	Y	N	COLON CANCER	Y	N
THYROID/ENDOCRINE DISORDER	Y	N	LYMPHOMA	Y	N

IN THE PAST YEAR HAVE YOU ENCOUNTERED

FREQUENT NAUSEA OR VOMITING	Y	N	FREQUENT CHEST OR ABDOMINAL PAIN	Y	N
VOMITING BLOOD OR COFFEE GROUNDS	Y	N	FREQUENT SHORTNESS OF BREATH	Y	N
BLOODY OR BLACK/TARRY STOOLS	Y	N	PRODUCTIVE COUGH	Y	N
CHANGE IN BOWEL OR BLADDER HABITS	Y	N	BLACKOUT SPELLS/SEIZURES	Y	N
CHANGE IN SIZE OF BOWEL MOVEMENTS	Y	N	JAUNDICE/DARKENED URINE	Y	N

Northeast Georgia Surgical Consultants

Name: _____ DOB: _____ Sex: _____ Age: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Telephone: _____ Alternative Phone: _____
Social Security Number: _____ Marital Status: _____
Responsible Party Name: _____ Responsible Party SSN: _____
Responsible Party DL#: _____ Responsible Party DOB: _____
Primary Care Physician: _____ Referring Physician: _____
Employer's Name & Address: _____
Spouse or Emergency Contact: _____ SSN (IF KNOWN): _____
Spouse or Contact Home Telephone: _____ Alternative Phone: _____
Spouse's Employer's Name & Address: _____
Insurance Company Name: _____
Policy #: _____ Group #: _____ Name of Insured: _____

Authorizations, Medical Records Release, Assignment of Benefits:

1. **Treatment Authorization:** I authorize you to give me reasonable and proper medical care by today's standards.
2. **Release of Information:** I authorize release of my records to Northeast Georgia Surgical Consultants, including Human Immunodeficiency Virus, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected disease, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with my utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities.
3. **Medical Lifetime Signature on File (if applicable):** I request that payment of authorized Medicare benefits be made to Northeast Georgia Surgical Consultants for any services furnished me by a member of this group. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or benefits payable for related services.
4. **Assignment of Benefits:** I request that payment of authorized insurance benefits be made on my behalf to Northeast Georgia Surgical Consultants for any services furnished to me.
5. **Financial Responsibility:** I understand that Northeast Georgia Surgical Consultants will file my insurance as a courtesy to me, and that I remain responsible for payment of copays, coinsurance, deductibles, non-covered services and any other charges not paid by insurance within 45 days.
6. **Patient Rights:** I have received a letter of patient rights from Northeast Georgia Surgical Consultants.

Signature: _____ Date: _____

PLEASE READ AND SIGN THIS FORM
Northeast Georgia Surgical Consultants, P.C.
Patient Consent for Use/Disclosure of Health Care Information

Patient's name: _____ Date of Birth: _____

I understand that my health information is private and confidential. I understand that Northeast Georgia Surgical Consultants (NGSC) works very hard to protect my privacy and preserve the confidentiality of the personal health information.

I understand that NGSC may use and disclose my personal health information (PHI) to help provide health care to me, to handle billing and payment, and to take care of the other health care operations. In general, there will be no other uses and disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

NGSC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. NGSC may update this "Notice of Privacy Practices" at any time. If I ask, NGSC will provide me with the most current "Notice of Privacy Practices".

Our Notice of Privacy Practices states that we may disclose your PHI to others who may assist in your care, such as your spouse, children, parents or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records.**

No Release to family/caregivers. If you wish to RESTRICT use/disclosure to TPO in other ways, please request a form.

Under the terms of this consent, I can ask NGSC to limit how my personal health information is used or disclosed to carry out treatment, payment or health care options. I understand that NGSC does not have to agree to my request. If NGSC does agree to my request, I understand that they would follow the agreed limits.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to NGSC. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations. If I revoke this consent, NGSC does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of NGSC's "Notice of Privacy Practices". My signature means that I agree to allow NGSC to use and disclose my patient's personal health information to carry out treatment, payment and health care operations.

Patient or legally authorized individual signature

Date

Relationship to patient if signed by anyone other than the patient.

