

**PREMIER SOUTH MEDICAL GROUP, P.C.**

**CONFIDENTIAL PATIENT INFORMATION SHEET**

(PLEASE PRINT)

**Date:** \_\_\_/\_\_\_/\_\_\_

**PATIENT DATA:**

PATIENT: (LAST NAME) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ UNIT/APT# \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ EXT. \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ SEX: \_\_\_ MALE \_\_\_ FEMALE

MARITAL STATUS: \_\_\_ SINGLE \_\_\_ MARRIED \_\_\_ DIVORCED \_\_\_ SEPARATED \_\_\_ WIDOWED

EMPLOYER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMERGENCY CONTACT: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

**INSURANCE, PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPYING EACH VISIT.**

PRIMARY INS. CO. NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY HOLDER'S SOCIAL SECURITY#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER'S D.O.B: \_\_\_/\_\_\_/\_\_\_

SECONDARY INS. CO. NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY HOLDER'S SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ POLICY HOLDER'S D.O.B: \_\_\_/\_\_\_/\_\_\_

**PLEASE LIST TWO NEAREST RELATIVES NOT LIVING WITH PATIENT**

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

**MEDICAL HISTORY**

**PAST MEDICAL HISTORY & REVIEW OF SYSTEMS**

**Please circle if you have had problems with or are presently complaining of any of the following:**

High Blood Pressure  
Diabetes  
Cancer  
Heart disease  
Chest pain/tightness  
Shortness of breath  
Swollen ankles  
Palpitations  
Lightheadedness  
Frequent urination  
Rheumatic Fever  
Asthma  
Bronchitis  
Pneumonia  
Persistent cough  
TB  
Hay fever  
Abdominal  
discomfort

Indigestion  
Nausea  
Vomiting  
Diarrhea  
Constipation  
Blood in stools  
Ulcers  
Change in bowel  
habits  
Unexplained weight  
loss/gain  
Hemorrhoids  
Gall bladder disease  
Colitis  
Hepatitis or jaundice  
Thyroid Disease  
Head or neck  
radiation  
Headache

Kidney disease  
Difficulty urinating  
Kidney stones  
Arthritis  
Low back problems  
Skin disease  
Blood disorder  
Venereal disease  
Anxiety  
Depression  
Anemia  
Alcohol abuse  
Drug abuse  
Gout  
\_\_\_\_\_  
\_\_\_\_\_

**EXPLAIN:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES TO MEDICATIONS, X-RAYS OR OTHER SUBSTANCES: \_\_\_\_ NO \_\_\_\_ YES**

(If yes, please list names of medicines and/or type of reaction):

\_\_\_\_\_

\_\_\_\_\_

**Please list the dates of:**

Operations: \_\_\_\_\_

Hospitalizations other than for surgery \_\_\_\_\_

When was your last Cholesterol check? \_\_\_/\_\_\_/\_\_\_      When was your last Prostate exam? \_\_\_/\_\_\_/\_\_\_

When was your stool last checked for blood? \_\_\_/\_\_\_/\_\_\_

**GYNECOLOGIC AND OBSTETRIC HISTORY**

Age at onset of period: \_\_\_ Frequency: \_\_\_\_\_ Date of last period: \_\_\_/\_\_\_/\_\_\_ Length of period: \_\_\_\_\_

Number of pregnancies: \_\_\_ Number of births: \_\_\_ Number of miscarriages: \_\_\_

Method of birth control: \_\_\_\_\_

Prolonged or abnormal bleeding: \_\_\_ No \_\_\_ Yes (please describe): \_\_\_\_\_

Leakage of urine:                      \_\_\_ No \_\_\_ Yes (please describe): \_\_\_\_\_

Pelvic Pain:                              \_\_\_ No \_\_\_ Yes (please describe): \_\_\_\_\_

Abnormal discharge:                \_\_\_ No \_\_\_ Yes (please describe): \_\_\_\_\_

History of abnormal Pap smears: \_\_\_ No \_\_\_ Yes (Please describe): \_\_\_\_\_

Date of last Pap smear: \_\_\_/\_\_\_/\_\_\_      Date of last Breast Exam: \_\_\_/\_\_\_/\_\_\_

Date of last Mammogram: \_\_\_/\_\_\_/\_\_\_

**IMMUNIZATION HISTORY** (have you had):

Tetanus immunization: \_\_\_ No \_\_\_ Yes    when: \_\_\_/\_\_\_/\_\_\_

Hepatitis B:                              \_\_\_ No \_\_\_ Yes    when: \_\_\_/\_\_\_/\_\_\_

Flu Vaccine:                              \_\_\_ No \_\_\_ Yes    when: \_\_\_/\_\_\_/\_\_\_

Pneumovax :                              \_\_\_ No \_\_\_ Yes    when: \_\_\_/\_\_\_/\_\_\_

**I \_\_\_\_\_ have been requested by Premier South Medical Group, P.C. to supply my immunization records. I understand that my immunization records are necessary to assist you in keeping my records up to date and accurate.**

**Signature:** \_\_\_\_\_ (signature of patient or legal guardian)

**FAMILY HISTORY**

Has any family member (to include parents, grandparents, and siblings) ever had the following?

<b><u>ILLNESS</u></b>	<b><u>WHICH FAMILY MEMBERS</u></b>	<b><u>APPROX. AGE(S) WHEN DIAGNOSED</u></b>
Cancer (type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Drug or Alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Mental disease (anxiety, Depression, etc.)	_____	_____
Other	_____	_____

**LIST MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBS and VITAMINS.)**

<b><u>DRUG NAME</u></b>	<b><u>DOSE</u></b>	<b><u>DRUG NAME</u></b>	<b><u>DOSE</u></b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PREVENTION**

- |                                                |                |                         |     |
|------------------------------------------------|----------------|-------------------------|-----|
| Do you smoke?                                  | ___ No ___ Yes | How many packs per day? | ___ |
| Do you drink? alcohol                          | ___ No ___ Yes | How many per week?      | ___ |
| Do you drink coffee?                           | ___ No ___ Yes | How many cups per day?  | ___ |
| Do you drink tea?                              | ___ No ___ Yes | How many cups per day?  | ___ |
| Do you use drugs<br>(marijuana, cocaine, etc.) | ___ No ___ Yes |                         |     |
| Do you wish to be tested for HIV/AIDS?         | ___ No ___ Yes |                         |     |
| Do you have a living will?                     | ___ No ___ Yes |                         |     |
| Do you have a donor card?                      | ___ No ___ Yes |                         |     |

**MEDICAL CONSENT \* ASSIGNMENT OF BENEFITS \* RELEASE OF INFORMATION**

**I, THE UNDERSIGNED, DO HEREBY AUTHORIZE THE PHYSICIAN, PHYSICIAN ASSISTANTS, NURSE PRACTITIONER AND STAFF OF PREMIER SOUTH MEDICAL GROUP, P.C. TO PROVIDE MEDICAL CARE FOR THE PATIENT LISTED BELOW.**

**I ALSO AUTHORIZE PREMIER SOUTH MEDICAL GROUP, P.C., TO RELEASE ANY AND ALL MEDICAL INFORMATION NECESSARY TO PROCESS ANY AND ALL INSURANCE CLAIMS FILED BY PREMIER SOUTH MEDICAL GROUP, P.C. ON MY BEHALF.**

**I HEREBY ASSIGN AND AUTHORIZE WITH MY SIGNATURE MY INSURANCE CARRIER(S) TO MAKE PAYMENT DIRECTLY TO PREMIER SOUTH MEDICAL GROUP, P.C.**

PATIENT NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

CELL PHONE :(\_\_\_\_) \_\_\_\_\_

SIGNATURE OF PATIENT (PARENT/GUARDIAN) \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PREMIER SOUTH MEDICAL GROUP, P.C. FINANCIAL POLICY**

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECKS, DEBIT, VISA, MASTER CARD AND AMERICAN EXPRESS.**

IN ORDER FOR PREMIER SOUTH MEDICAL GROUP, P.C. TO HONOR YOUR INSURANCE BENEFITS, YOU MUST PROVIDE US WITH YOUR CURRENT/ACTIVE INSURANCE CARD EACH TIME YOU VISIT OUR OFFICE.

IF YOUR INSURANCE PLAN REQUIRES A PRIMARY CARE PHYSICIAN, OUR PHYSICIAN'S NAME MUST BE LISTED ON YOUR INSURANCE CARD. IF WE ARE NOT LISTED AS YOUR PRIMARY CARE PHYSICIAN, YOU MAY PAY FOR SERVICES OUT OF POCKET OR YOU MAY RESCHEDULE YOUR APPOINTMENT ONCE YOU HAVE CHOSEN ONE OF OUR PHYSICIANS AS YOUR PRIMARY CARE PROVIDER.

IF YOU BELONG TO A MANAGED CARE INSURANCE PLAN, ALL APPLICABLE FEES ARE DUE AT THE TIME OF SERVICE. PLEASE REFER TO YOUR INSURANCE PLAN.

IF YOUR INSURANCE COMPANY HAS A DEDUCTIBLE AND YOU HAVE NOT MET YOUR DEDUCTIBLE, YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES IS RENDERED.

OUR OFFICE SUBMITS OUR CLAIMS ELECTRONICALLY TO YOUR INSURANCE COMPANY WITHIN 24 HOURS OF YOUR VISIT. IN THE EVENT THERE WAS A MISCALCULATION IN COLLECTION OF YOUR CO-PAY, CO-INSURANCE OR DEDUCTIBLE ON YOUR DATE OF SERVICE, WE ASK THAT ONCE YOU RECEIVE YOUR EXPLANATION OF BENEFIT AND YOUR RESPONSIBILITY EXCEEDS WHAT YOU PAID AT YOUR VISIT, WE ASK THAT YOU PLEASE REMIT THE DIFFERENCE TO: PREMIER SOUTH MEDICAL GROUP, P.C., 3890 REDWINE ROAD, SUITE 200, ATLANTA, GEORGIA 30331.

WHEN YOU COME TO THE OFFICE FOR AN APPOINTMENT AND THERE IS A BALANCE ON YOUR ACCOUNT, WE WILL REQUIRE PAYMENT OF THAT BALANCE AT THE TIME OF SERVICE.

THERE WILL BE A \$35.00 FEE FOR ANY CHECK OR DRAFT DISHONORED BY ANY FINANCIAL INSTITUTION.

IN THE EVENT PREMIER SOUTH MEDICAL GROUP, P.C., FINDS IT NECESSARY TO PLACE YOUR ACCOUNT WITH A COLLECTION AGENCY, YOU WILL BE CHARGED A FEE OF \$25.00 IN ADDITION TO THE BALANCE OF YOUR ACCOUNT.

**I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES RENDERED IN THE EVENT MY INSURANCE COMPANY DENIES PAYMENT IN FULL OR PART OF ANY SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO CO-PAYS, DEDUCTIBLE, NON-COVERED SERVICES AND SUPPLIES OBTAINED DURING THE COURSE OF MY CARE.**

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)

\_\_\_\_\_  
DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_