Georgia Clinic **Patient Information For Medical Records**

PATIENT INFORMATION

Name _____ Social Serurity # _____

Address _____ City _____ State _____ Zip _____

Age _____ Sex M / F Birth Date ____/____/____ Drivers License _____

Marital Status: ____Married ____ Single ____ Divorced ____Minor ____Widow

Work Phone (____)_____ Home Phone (____)_____

Who referred you to this office? _____ or ☐ Yellow Pages ☐ Ads ☐ Other_____

EMPLOYMENT INFORMATION: (PATIENT)

Employed by _____ Work Phone (____)_____

Work Address _____ Occupation _____

City _____ State _____ Zip _____

SPOUSE EMPLOYMENT:

Employed by _____ Work Phone (____)_____

Work Address _____ Occupation _____

City _____ State _____ Zip _____

NAME & ADDRESS OF NEAREST LIVING RELATIVE (Not living with you)

Name _____ Phone (____)_____

Address _____ Occupation _____

City _____ State _____ Zip _____

Reason for this visit: ____Illness ____ Injury ____Job Related Injury ____Auto Accident ____ Other _____

Date of injury or onset of problem _____ **HOW DO YOU INTEND TO PAY? __CASH __CHECK __CREDIT CARD**

Major Complaint _____

DO YOU HAVE INSURANCE THAT YOU WANT US TO FILL? ____INSURANCE ____MEDICARE ____OTHER

IF YOUR INJURY IS JOB RELATED: Name of person to authorize treatment _____

Company's Insurance Carrier _____ Insurance Carrier # _____ OK'd by _____

RESPONSIBLE PARTY

IF 18 & UNDER OR SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION:

Name of responsible party _____

Date of Birth: _____ Social Security #_____ Relation to Patient _____

IF DIFFERENCE FROM ABOVE:

Address _____ Phone (____)_____

City _____ State _____ Zip _____

Employed by _____ Work Phone (____)_____

Address _____ City _____ State _____ Zip _____

MEDICAL INSURANCE INFORMATION

PRIMARY Name _____

Address _____ City _____ State _____ Zip _____

Phone (____)_____ Date of Birth of Insured _____ Policy # _____

Group Name /# _____ ID # _____

SECONDARY Name _____

Address _____ City _____ State _____ Zip _____

Phone (____)_____ Date of Birth of Insured _____ Policy # _____

Group Name /# _____ ID # _____

I hereby give permission to Physicians at Georgia Clinic and staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Date: _____ Signed: _____

Payment is expected at the time of services. Please feel free to discuss any financial concerns you may have.

I, the undersigned, have insurance coverage with: _____ and assign directly to Physicians at Georgia Clinic all surgical and or medical benefits, if any payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits.

NOTE: Please notify us if any of the above information changes during the course of your treatmen.

MEDICAL HISTORY

A _____ Male _____

Patient name: _____ D.O.B. ____/____/____ Female _____

Allergies to Medications, X-Ray Dyes, or other Substances

_____No _____Yes

(If yes, please list name of medicine and type of reaction):

_____

_____

_____

Past Medical History and Review of Systems

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

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations/irregular heart heat
9. Lightheadedness
10. Stroke
11. Frequent urination
12. Rheumatic fever
13. Asthma
14. Ulcers
15. Sickle Cell
16. Bronchitis
17. Pneumonia
18. Persistent cough
19. T.B.
20. Hay fever
21. Abdominal discomfort
22. Indigestion
23. Nausea
24. Vomiting
25. Constipation
26. Diarrhea
27. Blood in stool
28. Breast lumps
29. Phlebitis
30. Change in bowel habits
31. Unexplained weight gain/loss
32. hemorrhoids
33. Gall bladder disease
34. Colitis
35. Hepatitis or jaundice
36. Thyroid disease
37. Head or neck radiation
38. headache
39. Kidney diseases
40. Kidney stones
41. Difficulty urinating
42. Breast/Nipple pain
43. AIDS
44. Arthritis
45. Low back problems
46. Skin diseases
47. Blood disorders
48. Venereal diseases
49. Anxiety
50. Depression
51. Anemia
52. Alcohol abuse
53. Drub abuse
54. Gout
55. Previous surgery
56. Previous hospitalizations
57. STD

_____

_____

Do you have a living WILL ____No ____Yes

Gynecologic and Obstetric History

Age at onset of periods _____ Frequency: _____ Length of period _____

Pregnancies: _____ Births: _____ Miscarriages _____

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 smear: ____ No ____ Yes (Please describe): _____

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history - have you had: Pneumovax immunizations? ____ No ____ Yes When? _____

Hepatitis B? ____ No ____ Yes When? _____ Flu immunization? ____ No ____ Yes When? _____

Family History

_____

_____

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hyperension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other:		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Signature (parent or guardian) _____ Patient Name: _____