EATONTON
Medical & Surgical

PATIENT INFORMATION

Patient Name: _____ Birth Date:_____ Sex: ☐ M ☐ F ☐ T

Home Address: _____ APT: _____ PO Box: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell: _____ Email: _____

Social Security Number: _____ Today's Date: _____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Email

Preferred Language: ☐ English ☐ French ☐ Hindi ☐ Italian ☐ Spanish ☐ Declined

Ethnicity: ☐ Non Hispanic ☐ Hispanic ☐ Declined

Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Other ☐ Declined

Height: _____ Weight: _____

Are you pregnant? ☐ Yes ☐ No If yes, how far along? _____

Do you exercise? ☐ Yes ☐ No How Often? ☐ Daily ☐ Weekly ☐ Monthly

Do you have osteoporosis? ☐ Yes ☐ No Date of last DEXA scan: _____

Are you up to date on immunizations? ☐ Yes ☐ No Date of last Tetanus: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Name: _____ Phone: _____

Next of Kin: Spouse/Parent _____ Phone: _____

Chief Complaint/Why are you here today? _____

_____

_____

_____

Have you seen any other physician regarding this condition, prior to coming to our office? ☐ Yes ☐ No

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PATIENT INFORMATION

Patient Name: _____ Birth Date: _____

Age :_____ Gender: _____

Pharmacy and Phone Number: _____

Medications Supplements/Herbal Remedies	Dose	Frequency	Reason for Medication

Are you allergic to any of the following? **Reaction:**

Penicillin: ☐ Yes ☐ No _____

Sulfa: ☐ Yes ☐ No _____

Betadine/Iodine: ☐ Yes ☐ No _____

Latex: ☐ Yes ☐ No _____

Tape: ☐ Yes ☐ No _____

Additional Allergies (Drug, Food, & Metal): _____

Past Surgical/Hospitilization History:

Date Surgery/Illness Doctor Hospital, City, State

_____

_____

Problems with General Anesthesia? ☐ Yes ☐ No _____

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Eatonton Medical and Surgical Center

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have had the opportunity to review and/or request a copy of this Notice of Privacy Practices of Eatonton Medical & Surgical Center on the date indicated below. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted at the office. I also understand that if I wish to receive additional copies, or if I have questions regarding this Notice of Privacy Practices, I may contact:
Eatonton Medical & Surgical Center, 132 Sparta Hwy, Eatonton, Georgia 31024

Information from EMSC may be left on the voicemail for phone #_____ ☐ Yes ☐ No

I also hereby authorize the following individual to have access to my medical records:
Name: _____
Relationshp: _____ Phone: _____

eRx Consent: ePrescribing software sends prescriptions over the internet to your pharmacy safely and securely, by applying the same technology used by credit card companies. ePrescribing software helps protect your personal information while allowing your provider access to important data such as drug interactions and prescription history.

I agree that ESMC may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.

By signing below, I acknowledge that I have read and understand the above.

Signature of Patient or Guarantor: _____
Print Name: _____
Responsible Party ot Parent Information (If Patient Under 18)

Name: _____
Sex: _____ DOB: _____
Address: _____
Phone # :_____
Work Phone #: _____
Social Security #: _____

INSURANCE
Primary Insurance: _____
Phone #: _____
Policy #: _____
Group #: _____
Subscriber Name: _____

Secondary Insurance: _____
Phone #: _____
Policy #: _____
Group #: _____
Subscriber Name: _____

Emergency Contact: _____
Phone #: _____

I authorize Eatonton Medical & Surgical Center to release to my insurance company, employer and/or referring physician, any information required in the course of my examination and treatment.
I also authorize any physician, hospital, or clinic to provide details of my history to Eatonton Medical & Surgical Center.

I hereby give consent to the providers of Eatonton Medical & Surgical Center for medical treatment. I hereby assign payment directly to Eatonton Medical & Surgical Center, for medical benefits payable for these services. I understand that I am responsible for payment of all services, including physician assistant and/or supply fees rendered regardless of insurance coverage. If a patient is a minor, I am responsible for payment of services.

By signing below, I have read and understand the above.

_____ _____
Patient/Responsible Party Signature Date

The person with minor patient is responsible for bill. By signing below, I understand that I am responsible for payment.

_____ _____
Signature Date

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PATIENT FINANCIAL POLICY

WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WE WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT. WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.

COPAYMENTS: Your insurance REQUIRES that we collect your designated copay at the time of service. Please be prepared to pay the copay at each visit.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, payment is required on the day of your appointment by cash, credit or debit card.

INSURANCE PLANS: As a service to our patients, we will bill your insurance if it is in-network. Any outstanding balances are the responsibility of the patient. It is YOUR responsibility to be aware of the office's participating status with your insurance.

ACCIDENT/WORKERS COMP CASES: For any work comp cases, initial appointments will only be scheduled through the employer. Patients shall be financially responsible for medical services related to accident/workers comp if insurance controverts the claim.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance should you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned, with check writing privileges suspended until the return check and fee is paid in full.

APPEALS: Should your insurance deny your claim, you give Eatonton Medical & Surgical the right to appeal your claim on your behalf.

MISSED APPOINTMENTS: Please cancel any appointments that you are unable to make so we can use your slot for another patient.

WE ACCEPT CASH, MAJOR CREDIT CARDS AND CHECKS: Accounts must be kept current in order to avoid being turned over to a collection agency. A 40% fee will be charged in addition to the amount turned over to the collection agency. For questions, call our Collections Manager at 706-485-8495.

CONSENT TO WIRELESS: I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

Patient Name (If different from Responsible Party): _____

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):* _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

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PATIENT HISTORY

Patient Social History:

Use of Alcohol:

- ☐ Never
- ☐ Rarely
- ☐ Moderately
- ☐ Daily

Smoking Status:*

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Use smokeless tobacco product
- ☐ Electronic cigarettes

*When did you start/stop smoking? _____

How many packs per day? _____

Family History - (If Yes, List family member, age of onset, and if deceased.)

Lungs/Breathing ☐ Yes ☐ No _____

Digestion/Heartburn ☐ Yes ☐ No _____

Bowel/Bladder/Prostrate ☐ Yes ☐ No _____

Diabetes ☐ Yes ☐ No _____

Heart Problems ☐ Yes ☐ No _____

High Blood Pressure ☐ Yes ☐ No _____

Headache ☐ Yes ☐ No _____

Bleeding Problems/Clots ☐ Yes ☐ No _____

HIV/AIDS ☐ Yes ☐ No _____

Cancer ☐ Yes ☐ No _____

Epilepsy ☐ Yes ☐ No _____

Anesthesia Problems ☐ Yes ☐ No _____

Neurological/Muscle Disease ☐ Yes ☐ No _____

Kidney/Liver Disease ☐ Yes ☐ No _____

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PATIENT HISTORY

Review of systems: Please indicate any personal history below. (Please Check All That Apply)

Musculoskeletal

Joint Pain	☐ No	☐ Yes
Joint Stiffness or swelling	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes
Injury	☐ No	☐ Yes

Genitourinary

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Renal disease	☐ No	☐ Yes

Psychiatric

Memory loss/Confusion	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Suicidal Thoughts	☐ No	☐ Yes

Constitutional Symptoms

Recent Weight Change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

Integumetary (skin, breast)

Rash or itching	☐ No	☐ Yes
Changes in skin color	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes

Gastrointestinal

Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Rectal bleeding/bloody stool	☐ No	☐ Yes
Abdominal Pain	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes

Ears/Nose/Mouth/Throat

Hearing loss/ringing	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes

Neurological

Light headed or dizzy	☐ No	☐ Yes
Numbness/tingling	☐ No	☐ Yes
Tremors	☐ No	☐ Yes

Respiratory

Chronic or frequent cough	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Exercise intolerance	☐ No	☐ Yes

Endocrine

Excessive thirst	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming drier	☐ No	☐ Yes

Allergic/Immunologic

List foods/environmental allergies

_____

_____

_____

Hematologic/Lymphatic

Enlarged glands	☐ No	☐ Yes
Bleeding or bruising	☐ No	☐ Yes

_____

Signature of Patient (or Parent of Minor) Date

EATONTON
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PATIENT HISTORY

PAST Medical History: Have you EVER had any of the following? Please check all pertinent boxes:

- ☐ Cancer: What type? _____
- ☐ Chest Pain/Angina
- ☐ Atrial Fibrillation
- ☐ Heart/Cardiac artery disease
- ☐ Congestive Heart Failure
- ☐ Blood Clot (DVT)
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Chicken Pox
- ☐ HIV or AIDS
- ☐ Measles
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Epilepsy/Seizure
- ☐ Back trouble
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD (chronic lung disease)
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pulmonary Embolus
- ☐ Sleep Apnea
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Chronic infection (Staph, MRSA)
- ☐ Glaucoma
- ☐ Anemia
- ☐ Diabetes
- ☐ Mitral Valve Prolapse
- ☐ Other (please list)
- ☐ _____

_____

_____

_____

_____

- ☐ High Cholesterol
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Venereal Disease

EATONTON
Medical & Surgical

132 Sparta Hwy
Eatonton, Georgia 31024
706.485.8495/Fax 706.485.8450

MEDICAL RECORDS RELEASE

FULL NAME: _____ **PATIENT DOB:** _____

SOCIAL SECURITY: _____ **CONTACT PHONE:** _____

I authorize and request *Eatonton Medical & Surgical Center* **to release copies of my medical information to** ***(this MUST be completed)*****:**

Name/Place: _____ **Phone #:** _____

Fax #: _____ **Address:** _____

******PLEASE NOTE THAT MEDICAL RECORDS REQUESTS CAN TAKE UP TO 7-10 BUSINESS DAYS******

For The Purpose Of:

- ❑ Personal
- ❑ Legal/Attorney
- ❑ Insurance Company
- ❑ Physician
- ❑ Other (Explain):

Portions of the Records being requested:

- ❑ Entire Chart (does not include billing and films)
- ❑ Billing
- ❑ Part of Body: _____
- ❑ Films **(unless personal request, you must arrange to pick up)**

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that your facility may have a fee for medical records in accordance with the State law. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to Medical Records at 132 Sparta Hwy, Eatonton, Georgia 31024, by sending a written request stating that I wish to revoke this Authorization to the attention of Medical Records at Eatonton Medical and Surgical. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize *EATONTON MEDICAL AND SURGICAL CENTER* (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

_____
Signature of Patient or Legal Representative (Patient must be 18 or over)

_____
Printed (legible) Name of Patient or Legal Representative

_____
Date Signed

If signed by Legal Representative, please provide the following information:

❑ Relationship to this patient:

_____
❑ Durable Power of Attorney for Healthcare
(Please provide copy)

EATONTON
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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release all medical records including history, finding, and prognosis to Eatonton Medical & Surgical Center. A copy shall be as valid as the original document.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that The Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage claim under the policy. I understand that my revocation must be submitted in writing to:
Medical Records 132 Sparta Hwy, Eatonton, Georgia 31024, by sending a written request stating that I wish to revoke this Authorization to the attention of Medical Records. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize *EATONTON MEDICAL & SURGICAL CENTER* (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

RECORDS FROM:

_____
Facility Name

_____ _____
Phone **Fax**

SENT TO:

EATONTON MEDICAL & SURGICAL CENTER
132 SPARTA HWY ***706-485- 8495(Phone)***
EATONTON, GEORGIA 31024 ***706-485-8450 (Fax)***

PATIENT NAME: _____ **DOB:** _____

SOCIAL SECURITY: _____ **PHONE #:** _____

_____ _____
Signature **of Patient or Legal Representative** ***Printed*** **(legible) Name of Patient or Legal Representative**

_____
Date Signed

If signed by Legal Representative, please check one:
- ❑ Relationship to this patient: _____
- ❑ Custodial Guardian
- ❑ Durable Power of Attorney for Healthcare