Rheumatology Center of Athens
1622 C Mars Hill Road
Watkinsville, GA 30677
Phone: 706-769-9931
Fax: 706-310-0499

Please Fill Out Completely:

Patient's Last Name					First Name			MI
Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other		Language
Address (Street, Route, Apt. No., etc.)					City	State	Zip Code	
Home Phone	Cell Number				Cell phone carrier (ex. Verizon)			
Email Address					Best way to contact (Circle one): Home Phone Cell Phone Email Letter			
Employed by								
Business Phone	Employer's Address				City	State	Zip Code	

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Address	City	State	Zip Code
Home Phone	Social Security	Date of Birth	Relationship to Patient	
Employed by		Business Phone		
Employer's Address		City	State	Zip Code
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)			Daytime Phone	

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____

_____

INSURANCE INFORMATION **(Please provide your insurance card(s) at the time of visit)**

Approved Lab for your Insurance Carrier: _____

_____ _____
Patient or Guardian Signature Date

Rheumatology Center of Athens
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

_____ _____
Patient Name (Print) Patient Date of Birth

_____ _____
Patient or Guardian Signature Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Rheumatology Center of Athens owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _____

_____

_____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

_____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for Rheumatology Center ofAthens and St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

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Authorization for Release of Medical Information

Patient: _____ Date of Birth: _____
(First) (Last)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

☐ Complete Health Record (or check for certain sections)

☐ ER Record	☐ Office Notes	☐ Echocardiogram Results
☐ History and Physical	☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)	☐ Nuclear Stress Test Results
☐ Discharge Summary		☐ CT Scan Results
☐ Consultation Report	☐ EKG	☐ Carotid-Vascular Study Results
☐ Operative Report	☐ Chest X-Ray Report	☐ Other as Specified_____
☐ Nursing Documentation	☐ Exercise Stress Test Results _____	

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

_____ Date: _____/_____/_____
Patient Signature

_____ Date: _____/_____/_____
Printed Name of Legal Representative

If signed by Legal Representative please provide the following:
Relationship to patient: _____
Authority to sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney for Healthcare
☐ Other, Please describe: _____

Records may be faxed and/or mailed to the fax number and the address provided above.

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Medical History Intake Sheet

Patient Name:_____ Birth Date: ____/____/_____ Date:_____

Describe your main problem today: _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

What other things happen with this problem? _____

_____

List previous hospitalizations/surgeries/serious injuries and when?

_____

_____

Social History:

Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(ed)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_____

Use of Tobacco: ☐ Never ☐ Previous but quit ☐ Current packs per day ____

Use of Drugs: ☐ Never ☐ Type/frequency_____

How often do you exercise? _____

Occupation: _____

Family Medical History:

Do you have any family history of the following conditions?
(Check all that apply, leave blank if not applicable)

ð	Rheumatoid Arthritis	ð	TB	ð	Inflammatory Bowel (Crohn's or Ulcerative Colitis)
ð	Psoriasis	ð	Diabetes		
ð	Thyroid disease	ð	Cancer	ð	Gout
ð	Systemic Lupus				

	Age	Disease	If Deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____

Rheumatology Center of Athens

Name: _____ **Date:** _____

In the last 2 weeks, have you had any of the following symptoms? **(Check all that apply, leave blank if not applicable)**

eneral:
- ☐ Weight Loss
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Swollen Lymph nodes

HEENT:
- ☐ Scalp tenderness
- ☐ Dry Eyes
- ☐ Gritty Eyes
- ☐ Red Eyes
- ☐ Double Vision
- ☐ Vision loss
- ☐ Oral ulcers
- ☐ Nasal ulcers
- ☐ Dry mouth
- ☐ Trouble swallowing dry food
- ☐ Sinusitis

Cardiovascular/Pulmonary:
- ☐ Chest Pain
- ☐ Murmur
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Shortness at breath lying flat
- ☐ Shortness of breath at night
- ☐ Cough
- ☐ Wheezing
- ☐ Hemoptysis
- ☐ Deep Vein Thrombosis
- ☐ High blood pressure
- ☐ Leg edema

lusculoskeletal:
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Low back pain
- ☐ Morning stiffness
- ☐ Heel pain
- ☐ Sausage digits
- ☐ Hypermobility
- ☐ Weakness
- ☐ Joint swelling
- ☐ Tingling/pins and needles feeling

Gastrointestinal:
- ☐ Difficulty swallowing
- ☐ Reflux
- ☐ Peptic Ulcer Disease
- ☐ Diarrhea
- ☐ Constipation
- ☐ Dark tarry stools
- ☐ Abdominal pain
- ☐ Blood transfusion
- ☐ Hepatitis

Genitourinary:
- ☐ Painful urination
- ☐ Genital ulcers
- ☐ Sexually transmitted disease
- ☐ Kidney stones
- ☐ Regular periods
- ☐ History of Sexual Abuse

Dermatologic:
- ☐ Rashes
- ☐ Sun sensitivity
- ☐ Hair loss
- ☐ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ Skin tightening
- ☐ Nail changes

Misc:
- Trouble falling asleep
- Awakenings
- Unrefreshed sleep
- Loud snoring
- Headaches
- Jaw claudication
- Depression
- Tick exposure
- Limb weakness
- Dizziness

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Current Medications

List all medications you are currently taking including nonprescription and/or herbal supplements

Medication Name	Strength	Dosage
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		

Attach an additional sheet if necessary

Allergies:

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eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Rheumatology Center of Athens may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature (or legal guardian) Print Patients Name

_____ _____

Primary Pharmacy Name Pharmacy Street and City

_____ _____

Secondary Pharmacy if applicable Pharmacy Street and City

_____

Date