



**Patient Registration Forms**

**Please Fill out Completely**

Date:	Are you a patient of any other St. Mary's Medical Group location? YES NO If yes, what other locations?				Name of Physician you are scheduled to see			
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			Do any other family members use this email address? List names			Best way to contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Letter		
<b>EMPLOYER INFORMATION</b>								
Employed by				Occupation				
Business Phone		Employer's Address			City	State	Zip Code	
<b>SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)</b>								
Name				Relationship to patient		Responsible for bill: YES NO		
Home Phone		Social Security		Date of Birth	Sex			
Employed by				Business Phone				
Employer's Address				City	State	Zip Code		
<b>EMERGENCY CONTACT</b>								
Name		Relationship	Home Phone		Work Phone	Mobile Phone		
<b>PHYSICIAN INFORMATION</b> <i>Complete this section only if applicable</i>								
Primary Care Physician Name				Phone				
Address				City	State	Zip Code		
Referring Physician Name				Phone				
Address				City	State	Zip Code		
<b>INSURANCE INFORMATION (Please provide your insurance card(s) at the time of visit)</b>								
Primary Insurance Name		Subscriber Name		Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO	
Secondary Insurance Name		Subscriber Name		Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO	

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date



ST. MARY'S HEALTH CARE SYSTEM, INC. ("SMMG") CONSENT/AUTHORIZATIONS

**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 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  
St. Mary's Health Care System, Inc.**

Patient Name _____
Address: _____ _____
Date of Birth: _____



## Authorization for Release of Medical Information

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

Patient Name		Date of Birth	Last 4 digits of SSN
Address		City	State Zip
<b>Please circle: I authorize St. Mary's Medical group to <u>OBTAIN</u> or <u>RELEASE</u> records from:</b>			
Name/Organization			
Address		Phone	Fax
<b>Please send records to:</b>			
Name/Organization			
Address		Phone	Fax
<b>If records are to be released from SMMG, please indicate which location. Check all that apply.</b>			
<input type="checkbox"/> Athens Internal Medicine Associates <input type="checkbox"/> Community Medicine of Athens <input type="checkbox"/> Georgia Family Medicine <input type="checkbox"/> Johnson and Murthy Family Practice <input type="checkbox"/> Lighthouse Family Practice <input type="checkbox"/> Middle GA Medical Associates <input type="checkbox"/> St. Mary's Internal Medicine Associates <input type="checkbox"/> Hometown Pediatrics		<input type="checkbox"/> Athens General and Colorectal Surgeons <input type="checkbox"/> Clear Creek OBGYN <input type="checkbox"/> Endocrine Specialists of Athens <input type="checkbox"/> Infectious Disease Specialists of Athens <input type="checkbox"/> Northeast Cardiology <input type="checkbox"/> Oconee Heart and Vascular Center <input type="checkbox"/> Rheumatology Center of Athens <input type="checkbox"/> St. Mary's Neurological Specialists	
<b>Purpose of Release?</b> <input type="checkbox"/> Insurance <input type="checkbox"/> Personal <input type="checkbox"/> Treatment Elsewhere <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Legal <input type="checkbox"/> Other _____			
<b>What type of records/reports should be released?</b>			
<input type="checkbox"/> Complete Record <input type="checkbox"/> ER Record <input type="checkbox"/> Office Notes <input type="checkbox"/> History and Physical <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Consultation Report <input type="checkbox"/> Surgical/Operative Report	<input type="checkbox"/> Most recent lab work <input type="checkbox"/> Echo <input type="checkbox"/> Nuclear Stress Test <input type="checkbox"/> Exercise Stress Test <input type="checkbox"/> EKG <input type="checkbox"/> Carotid/Vascular Study <input type="checkbox"/> Chest X-Ray	<input type="checkbox"/> Mammogram <input type="checkbox"/> CT Scan _____ <input type="checkbox"/> MRI _____ <input type="checkbox"/> EEG <input type="checkbox"/> EMG/NCS <input type="checkbox"/> Other: _____	

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.

\_\_\_\_\_  
**Patient Signature/Legal Representative Signature**

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

\_\_\_\_\_  
**Printed Name of Legal Representative**

\_\_\_\_\_  
**Relationship to patient**



## St. Mary's Medical Group 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 St. Mary's Medical Group 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



## Medical History

Please take a few minutes to fill out our health history forms. Please fill in all areas, before your appointment. Your answers will help our providers plan for your visit and provide you the best care.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Reason for visit/main problem: \_\_\_\_\_ Where is your problem located: \_\_\_\_\_

How long have you had this problem: \_\_\_\_\_ What makes it worse or better: \_\_\_\_\_

**ADVANCE DIRECTIVES:** *Please check all that apply*

Do you have a Power of Attorney for health care?  No  Yes Designated Individual: \_\_\_\_\_

Do you have a living will/Do Not Resuscitate?  No  Yes

Are you an organ donor?  No  Yes

**PATIENT CARE TEAM:** *Please answer each question*

Specialty:	Name/Group:	Last Visit Date:	Specialty:	Name/Group:	Last Visit Date:
Cardiologist			OBGYN		
Neurologist			Eye Doctor		
Surgeon			Pulmonologist		
Dermatologist					
Gastro					

**CURRENT MEDICAL HISTORY:** *Please check all that apply*

<input type="checkbox"/> Addiction <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Asthma <input type="checkbox"/> Bipolar <input type="checkbox"/> Colon Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Reflux/GERD <input type="checkbox"/> Blood Clot <input type="checkbox"/> Heart Attack	<input type="checkbox"/> Hepatitis type: _____ <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Migraines <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Skin Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease	Are you currently under treatment/s for Cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____ _____ _____ Other Mental Illness: _____ _____ _____ Other Illness: _____ _____ _____	Have you fallen in the last 2 months? <input type="checkbox"/> No <input type="checkbox"/> Yes  Have you fallen in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes
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**HOSPITALIZATIONS/SURGERIES:** *Please check all that apply*

<input type="checkbox"/> Appendectomy <input type="checkbox"/> Coronary Artery Bypass (Open Heart) <input type="checkbox"/> Carotid Endarterectomy <input type="checkbox"/> Cholecystectomy (Gallbladder) <input type="checkbox"/> Bariatric Type: _____	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Nephrectomy <input type="checkbox"/> Splenectomy <input type="checkbox"/> Tonsillectomy/Adenoidectomy	<input type="checkbox"/> Other surgeries: _____ _____ <input type="checkbox"/> Other Hospitalizations: _____ _____ _____
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**FAMILY MEDICAL HISTORY:** *Please check all that apply and check all family members that apply*

Illness	Relation to you
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Paternal Grandparent <input type="checkbox"/> Maternal Grandparent
<input type="checkbox"/> Anemia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Paternal Grandparent <input type="checkbox"/> Maternal Grandparent
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Paternal Grandparent <input type="checkbox"/> Maternal Grandparent
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Paternal Grandparent <input type="checkbox"/> Maternal Grandparent
<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Child <input type="checkbox"/> Paternal Grandparent <input type="checkbox"/> Maternal Grandparent



<b>IMMUNIZATIONS: Please check all that apply **Please bring a copy of your immunization records to your appointment**</b>			
Vaccine	Administered Date	Vaccine	Administered Date
Tetanus		Shingles	
Pneumonia		HPV	
Flu Shot		Meningitis	
Hep B		Hep A	
<b>PREVENTIVE CARE: Please list the dates of your last test, facility test was performed and the results if known.</b>			
Test	Date	Facility	Results
Mammogram			
Pap Smear			
Colonoscopy			
Hemoccult			
Dexa/Bone Density			
PSA			
<b>DEPRESSION SCREENING: Please answer both questions.</b>			
Over the past two weeks, I have had little interest or pleasure in doing things: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Over the past two weeks, I have felt down, depressed or hopeless: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have a past history of depression? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you currently being treated for depression? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>REVIEW OF SYSTEMS: Check all symptoms below that you are CURRENTLY experiencing.</b>			
<b>General</b> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <b>Eyes</b> <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Change in vision <b>Musculoskeletal</b> <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle aches <b>Dermatologic</b> <input type="checkbox"/> Suspicious lesions <input type="checkbox"/> Itching <input type="checkbox"/> Rash <b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Sleep problems	<b>ENT</b> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Voice change <input type="checkbox"/> Sinus problems <b>Cardiovascular</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Racing/skipping beats <input type="checkbox"/> Swelling (feet/legs/hands) <input type="checkbox"/> Leg pain with exertion <input type="checkbox"/> Varicose veins <b>Hematological</b> <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> Anemia <b>Allergy</b> <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Food allergies <input type="checkbox"/> Year round allergies	<b>Respiratory</b> <input type="checkbox"/> Sleep disturbance due to breathing <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Excessive snoring <b>Female Genitourinary</b> <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast discharge <input type="checkbox"/> Pain with periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Vaginal discharge <b>Genitourinary</b> <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary hesitancy <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Incontinence <input type="checkbox"/> Decreased libido <b>Male Genitourinary</b> <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Testicular pain	<b>Gastrointestinal</b> <input type="checkbox"/> Indigestion/heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Dark tarry stools <input type="checkbox"/> Bloody stools <b>Neurological</b> <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Headaches <input type="checkbox"/> Falling down <input type="checkbox"/> Weakness <input type="checkbox"/> Tremors <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Vertigo <b>Endocrine</b> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive urination <input type="checkbox"/> Excessive thirst
<b>Additional information you would like to share with the provider:</b>			