

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening
Cellular _____ Pager _____

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Patient Relationship to Emergency Contact _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____

Clarke-Oconee Family Practice
1010 Prince Avenue Suite 182
Athens, Georgia 30606

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Clarke-Oconee Family Practice** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Clarke-Oconee Family Practice** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Clarke-Oconee Family Practice**.

I acknowledge that I have been given the **Clarke-Oconee Family Practice** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date

NEW PATIENT HISTORY AND PHYSICAL

NAME _____ **BIRTH DATE** _____ **DATE** _____

WHY ARE YOU HERE? _____

HISTORY OF ILLNESS - MUST ANSWER ALL THE FOLLOWING QUESTIONS

WHERE IS YOUR PROBLEM? _____

WHERE WERE YOU WHEN YOU NOTICED THIS PROBLEM? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HOW SEVERE IS YOUR PROBLEM? _____

WHAT MAKES IT BETTER OR WORSE? _____

ALLERGIES	FAMILY HISTORY					
	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CURRENT MEDICATIONS						
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY			
DATE	REASON	DATE	REASON

REPRODUCTIVE HISTORY

WOMEN: LMP _____ LAST PAP SMEAR _____ **MEN:** SEXUAL DYSFUNCTION _____
 G _____ P _____ AB _____ LAST MAMMOGRAM _____
 PROSTATE DISEASE _____
 WOMEN ONLY PREGNANT YES NO
 PLANNING PREGNANCY? YES NO
 LAST PSA (Prostate Specific Antigen) _____

PAST MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> HEADACHE
<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> HEART PALPITATIONS
<input type="checkbox"/> HEART MURMUR
<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> DIZZINESS/FAINTING
<input type="checkbox"/> PERIPHERAL VASCULAR DISEASE
<input type="checkbox"/> ALLERGIES/HAY FEVER
<input type="checkbox"/> ASTHMA
<input type="checkbox"/> BRONCHITIS
<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> ULCER
<input type="checkbox"/> GI DISORDER | <input type="checkbox"/> GALL BLADDER DISEASE
<input type="checkbox"/> DIABETES
<input type="checkbox"/> BOWEL IRREGULARITY
<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> KIDNEY PROBLEMS
<input type="checkbox"/> HEPATITIS
<input type="checkbox"/> ANEMIA
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> NERVOUSNESS
<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> GOUT
<input type="checkbox"/> HYPERTENSION
<input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CANCER
<input type="checkbox"/> RHEUMATIC/SCARLET FEVER
<input type="checkbox"/> MUMPS
<input type="checkbox"/> MEASLES
<input type="checkbox"/> CHICKEN POX
<input type="checkbox"/> LUNG DISEASE
<input type="checkbox"/> SICKLE CELL/CYSTIC FIBROSIS
<input type="checkbox"/> SEIZURES
<input type="checkbox"/> COLONOSCOPY
IMMUNIZATIONS
Influenza _____ Hep-B _____
Tetanus _____ Shingles _____
Pneumovax _____ Typhoid _____ |
|---|--|---|

SOCIAL HISTORY

SNUFF: AMOUNT DAILY _____ SMOKE: AGE STARTED / AMOUNT DAILY _____
 EXERCISE ROUTINE _____ ALCOHOL: TYPE/AMOUNT _____

DIET RESTRICTIONS: _____ CONTACT WITH BLOOD OR BODY FLUID AT WORK _____
 PAST DRUG USE: _____ NUMBER OF SEXUAL PARTNERS: ____: MALE. ____: FEMALE.

PATIENT _____ **PHYSICIAN** _____
 Signature _____ Date _____ Signature _____ Date _____

REVIEW OF SYSTEMS:

PLEASE CIRCLE Y (YES) OR N (NO) IF YOU HAVE OR ARE EXPERIENCING THE ISSUES BELOW:

PATIENT NAME _____ DATE _____

CONSTITUTIONAL: Subjective fever Y N. Documented Fever Y N. Chills Y N. Night sweats Y N. Weight loss-recent Y N. Cancer Y N. Chronic Fatigue Y N.

ENDOCRINE: Hyperlipidemia (Elevated Cholesterol) Y N. Diabetes Y N. Thyroid disease Y N.

HEMATOLOGIC/LYMPHATIC: Anemia Y N. Bruise easily Y N. Bleeding diseases (Free Bleeder) Y N. Are You Taking Blood thinners Y N.

ALLERGIES: Medication Allergies Y N. If so what are your allergies: _____.

HEENT: Decreased Hearing Y N. Ringing in ears Y N. Frequent ear infections Y N. Nose bleeds Y N. Sinus trouble Y N. Sore throats Y N. Hay fever Y N. Allergies Y N.

EYES: Failing vision Y N. Double/blurred vision Y N. Eye pain Y N. Eye infections Y N.

RESPIRATORY: Pneumonia Y N. Bronchitis Y N. Chronic cough Y N. Asthma Y N. Wheezing Y N. Shortness of Breath Y N. on Exertion Y N. when lying flat Y N.

CARDIOVASCULAR: Hypertension Y N. Chest pain Y N. on exertion Y N. at rest Y N. Heart murmur Y N. Palpitations Y N. Irregular Pulse Y N. Swollen ankles Y N. Fainting spells Y N. Leg pain with walking Y N. Varicose veins Y N. Phlebitis (Inflammation of the veins) Y N. Cold numb feet Y N.

GASTROINTESTINAL: Loss of appetite recent Y N. Difficulty swallowing Y N. Heartburn Y N. Peptic ulcers Y N. Abdominal pain Y N. Nausea Y N. Vomiting Y N. Diarrhea Y N. Constipation Y N. Diverticulosis Y N. Blood or tarry stools Y N. Hemorrhoids Y N. Gall bladder trouble Y N. Hepatitis Y N.

GU/GENT: Hernia Y N. Urine infections frequent Y N. Painful urination Y N. Blood in urine Y N. Overnight urination-more than 2 times Y N. Control of urination Y N. Decrease in force urination Y N. Kidney stones Y N. Venereal disease Y N.

GYN/FEMALE: Gravida (Number of Pregnancies) _____. Para (Number of live births) _____. Abortion/Miscarriages (Number) _____. Menarche (Age of starting menstrual cycles) _____. Irregular menstruation Y N. Flushing Y N. Menopause Y N.

MUSCULOSKELETAL: Back pain recurrent Y N. Bone fractures Y N. Joint injury Y N. Gout Y N. Foot pain Y N. Arthritis/Rheumatism Y N. Muscle weakness Y N. Muscle pain Y N.

INTEGRA/SKIN: Rashes Y N. Hives Y N. Psoriasis Y N. Eczema Y N. Acne Y N.

NEURO: Headaches Y N. Migraines Y N. Dizzy spells Y N. Seizures Y N. Stroke Y N. Tremor/Hands shaking Y N. Numbness/Tingling sensations Y N.

PSYCH: Sleeping difficulty Y N. Nervousness Y N. Depression Y N. Memory loss Y N. Excessive moodiness Y N.

CHILDHOOD ILLNESSES/ADULT ILLNESSES: Chicken Pox Y N. Measles Y N. Polio Y N. German Measles Y N. Rheumatic Heart Disease Y N. Scarlet Fever Y N. Mumps Y N. Tuberculosis Y N.

PATIENT _____
Signature _____

Date

PHYSICIAN _____
Signature _____

Date

Office Policies

Scheduling Appointments

Scheduling is a critical issue in every physician's office. *Clarke Oconee Family Practice* is no exception. Our physician's schedule reflects the amount of time necessary to assist you with your medical issues. While our staff makes every effort to stay on established schedules, there may be occasions when you will have to wait due to an emergency. We make every effort to keep these delays to a minimum.

Missed Appointment Policy

To better serve our patients and minimize costs, please make note that a missed appointment will result in the following charge:

- Office Visit - \$25.00
- Procedures - \$35.00

To avoid these charges, please reschedule one working day (24 hours) before your appointment. This fee will be due before being seen at your next appointment.

Payment

- *Clarke Oconee Family Practice* accepts cash, checks and credit cards.
- Payment is expected BEFORE being seen by the physician.
- If you are paying with cash, please have the correct amount (i.e. The amount of your insurance co-pay.)
- If you need to set up a payment plan, a member of our Business Office staff will be glad to help you.

Initial: _____

For New Patients

Please arrive at least 30 minutes before your appointment, allowing ample time for traffic and parking. You will need this time to complete and sign any forms, and time for our staff to make the necessary copies of your insurance information.

Please make sure you have your **current** insurance card and photo ID when you arrive for your appointment.

For Established Patients

Each time you visit the office, please make sure that we have the **most current** insurance information and demographic information (address, phone numbers, etc.)

Please arrive 15 minutes before your appointment, allowing ample time for traffic and parking. If you are more than 15 minutes late for your appointment, you will have to be rescheduled.

Prescriptions will no longer be called into the pharmacy. If you need a refill, you need to contact the pharmacy and have them send us a refill request. The physician will not refill any prescriptions if you did not keep your last appointment or if it has been more than six (6) months since your last appointment. If you need a new prescription, you will need to schedule an appointment to be seen by the physician.

Patient Name:

Date:

Signature:

Witness Signature:

Date:

To Our Clients:

In an effort to keep up with the latest technology and procedures we have recently expanded our menu of services. We are now offering a full line of cosmetic laser procedures. Please take a few moments to review the new services and let us know if you are interested in scheduling a free consultation.

Please check the box next to the service(s) in which you are interested.

- Fade and eliminate fine lines and wrinkles
- Repair sun damaged skin
- Eliminate unwanted hair
- Treat spider veins on the face and legs
- Even skin tone and texture
- Free Consultation

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Email (for our use only) _____

Phone Number: _____

Have you had laser treatments in the past? _____

If "Yes" please explain: _____

Best time to call: _____

CLARKE-OCONEE FAMILY PRACTICE

Payment Policy

Revised 5-1-04

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If this is the case, we will explain all non-covered services and their cost before any testing is performed. You will be asked to sign a form stating your understanding.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We will need a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of you claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, it will be placed with a collection agency. Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the patients balance, and become the responsibility of the patient or guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please initial here after reading number 7. _____
8. **Missed appointments.** Our policy is to charge \$25 for each missed appointment not cancelled within 24 hours. This charge will be your responsibility and billed directly to you. After three no show appointments, you will be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or responsible party

Date