MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present Health or Cause of Death	MOTHER	Present Health or Cause of Death	SPOUSE	Present Health or Cause of Death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	

BROTHERS	NO. ALIVE	HEALTH	HOW MANY DECEASED	CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH	HOW MANY DECEASED	CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH	HOW MANY DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

5 MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

6 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed by — Date

RENEW HEALTH MEDICAL CENTER
1550 JANMAR ROAD, SUITE B
SNELLVILLE, GA 30078

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE PROCEDURES:

I consent to the use or disclosure of my protected health information by Renew Health Medical Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare procedures.

I understand that my diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document, and that I have the right to revoke this consent in writing at any time except that the above named healthcare provider has taken action in reliance on this consent.

I have reviewed Renew Health Medical Center's Notice of Privacy Practices, which describes the ways in which my health information may be used and disclosed and explains my rights regarding my health information.

_____

Signature of Patient *or* Legal Guardian (if patient under 18)

_____

Printed Name of Patient

_____

Date

The above party may disclose this health information to the following recipient:
Name and relationship _____
Address _____
City _____ **State** _____ **Zip** _____
Phone _____ **Email** _____

This authorization ends:
☐ **- On (date)**_____
☐ **- When the following event occurs:** _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:

ID#: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

RENEW HEALTH MEDICAL CENTER
1550 Janmar Road, Suite B
Snellville, GA 30078
770-822-3031

Financial Policy
Patient Financial Agreement

Renew Health Medical Center is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and **making your copay and deductible payments at the time of your office visit with cash, check or credit card.** **PATIENT INITIAL** _____

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Renew Health Medical Center will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. **PATIENT INITIAL** _____

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please call your insurance company or the we are referring to before scheduling. **PATIENT INITIAL** _____

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Renew Health Medical Center for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits. **PATIENT INITIAL** _____

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer. **PATIENT INITIAL** _____

Patient Name: (Print)_____

_____ _____
Patient Signature Date

Patient's Medicare Number:_____

I have read and I understand Renew Health Medical Center's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____
Patient Signature **Date**

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Renew Health Medical Center and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Renew Health Medical Center's services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Renew Health Medical Center is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay my balance at the time the services are rendered. I also understand that claims can be partially paid and could be responsible for an additional balance.

_____ (initial) I agree to give Renew Health Medical Center my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment.

_____ (initial) I agree that if my insurance benefit requires me to change my Primary Care Provider and it is not done before my appointment, that I will totally responsible for all charges of my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour notice was not given. There will be a fee of $30.00 for any missed office visits.

_____ (initial) I understand there will be a $35.00 fee for all returned Checks

_____ (initial) If I do not currently have insurance benefits, I agree to pay for my office visit at the time of service.

_____ (initial) Renew Health Medical Center has a contract with my insurance company. Renew Health Medical Center will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Renew Health Medical Center my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Renew Health Medical Center pursuing any collection means possible.

_____(initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____(initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Renew Health Medical Center the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Renew Health Medical Center can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit. I also understand that Renew Health Medical Center **does not file claims to third party auto insurance companies.**

I have read and I understand Renew Health Medical Center's financial policies and I accept responsibility for the payment of any fees associated with my care.

X _____ _____

Patient Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Renew Health Medical Center, LLC. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me.

I have read and I understand Renew Health Medical Center's financial policies and I accept responsibility for the payment of any fees associated with my care.

X _____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

MEDICAL RELEASE AUTHORIZATION

I authorized _____ to be able to obtain my medical record and health information. This will remain in effect until I notify the office in writing.

Relationship to Patient: _____

****** If no one applies, then mark N/A*******