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: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Letter

EMPLOYER INFORMATION

Employed by	Occupation

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	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

EMERGENCY CONTACT

Name	Relationship	Home Phone	Work Phone	Mobile Phone

PHYSICIAN INFORMATION

Complete this section only if applicable

Primary Care Physician Name	Phone		
Address	City	State	Zip Code
Referring Physician Name	Phone		
Address	City	State	Zip Code

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

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

Please circle: I authorize St. Mary's Medical group to OBTAIN or RELEASE records from:
Name/Organization

Address	Phone	Fax

Please send records to:
Name/Organization

Address	Phone	Fax

If records are to be released from SMMG, please indicate which location. Check all that apply.

- ☐ **Athens Internal Medicine Associates**
- ☐ **Community Medicine of Athens**
- ☐ **Georgia Family Medicine**
- ☐ **Johnson and Murthy Family Practice**
- ☐ **Lighthouse Family Practice**
- ☐ **Middle GA Medical Associates**
- ☐ **St. Mary's Internal Medicine Associates**
- ☐ **Hometown Pediatrics**
- ☐ **Athens General and Colorectal Surgeons**
- ☐ **Clear Creek OBGYN**
- ☐ **Endocrine Specialists of Athens**
- ☐ **Infectious Disease Specialists of Athens**
- ☐ **Northeast Cardiology**
- ☐ **Oconee Heart and Vascular Center**
- ☐ **Rheumatology Center of Athens**
- ☐ **St. Mary's Neurological Specialists**

Purpose of Release? ☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal
☐ Other ____

What type of records/reports should be released?

- ☐ Complete Record
- ☐ ER Record
- ☐ Office Notes
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Surgical/Operative Report
- ☐ Most recent lab work
- ☐ Echo
- ☐ Nuclear Stress Test
- ☐ Exercise Stress Test
- ☐ EKG
- ☐ Carotid/Vascular Study
- ☐ Chest X-Ray
- ☐ Mammogram
- ☐ CT Scan __________________
- ☐ MRI _____________________
- ☐ EEG
- ☐ EMG/NCS
- ☐ 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.

____ **Date: _____/______/________**

Patient Signature/Legal Representative Signature

____ ___________________________

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

St. Mary's Neurological Specialists
St. Mary's Medical Group

Patient Name: ____ Age: ____ Date of Birth _____________
Dominant Hand: __________

Please describe the main problem you are here to see a neurologist about today:

____

____

Medical and Surgical History –

Please check any disease or condition you have had in the past or have now:

High blood pressure	Diabetes	Heart failure	Arthritis
Asthma	Glaucoma	Heart attack	Anemia
COPD/emphysema	Liver disease	Thyroid disease	Stroke
Kidney failure	Acid reflux/ulcers	Fibromyalgia	Migraines
Kidney stones	Seizures/Epilepsy	Depression	Anxiety
High cholesterol	Muscle disease	Dementia	Neuropathy

Cancer (where? _________________ when? ________ therapy ___________________)

Please list any other health problems not described above or describe above condition further:

____

____

Please list any surgeries you have had and the approximate dates:

____

____

____

Current Medications: Please provide a list of your **medications or write them here**

Name	Strength (mg)	# of Tablets	# of Times per day

St. Mary's Neurological Specialists
St. Mary's Medical Group

What over the counter medications or remedies do you take?

____

____

List/describe any "alternative" or "complementary" therapies you are receiving:

____

____

Medication allergies: ____

Family History

Relative:	Father	Mother	Brother(s)	Sister(s)	Children
Age (if living)					
Cause/Age at time of death					
Cancer					
Seizures					
Stroke					
Heart attack					
Migraines					
Dementia					
Neuropathy					
Muscle problems					
Diabetes					
Parkinson's disease					
Psychiatric illness					
Multiple Sclerosis					
High blood pressure					

Social History

Do you smoke?

No Did you ever smoke? ______ If so, how much? __________________ How long? ____________________
When did you quit? __________________________

Yes How much per day? _________ For how many years? ________________

How much caffeine do you drink/day? ____
How much alcohol do you drink per day, week or month? __________________________

Family: Single Married Divorced Widowed Significant other/Partner
Do you have children? _____ How many? ________ What are their ages? _____________

Occupation: ____
Educational level (how far did you go in school?): ________________________________
Do you use recreational drugs (such as marijuana, cocaine, heroin)? __________________

St. Mary's Neurological Specialists
St. Mary's Medical Group

Review of Systems: Please check symptoms you have had in the **PAST 3 MONTHS** only**.**

Constitutional

Weight loss	Recurrent Fevers	Weight gain

Ophthalmology

Diminished vision	Blurred vision	Double vision
Flashing lights in the eyes		

ENT

Loss of hearing	Ringing in the ears	Difficulty swallowing
Snoring/daytime sleepiness		

Cardiac/Respiratory

Chest pain	Shortness of breath	Palpitations
Leg swelling		

GI

Abdominal pain	Chronic diarrhea	Chronic constipation
Loss of bowel control	Nausea/vomiting	Blood in stool

GU

Loss of bladder control	Sexual difficulties	Blood in urine

Musculoskeletal

Neck pain	Back pain	Muscle cramping/stiffness
Joint pain	Joint stiffness	Joint swelling

Endocrine

Fatigue	Intolerant of cold	Intolerant of heat
Hair loss		

Hematologic

Easy bruising	Excessive bleeding	Frequent infections

Neurologic

Numbness of arms/legs	Weakness of arms/legs	Memory loss
Vertigo/spinning feeling	Tremors/Shaking	Difficulty walking
Poor balance	Passing out	Severe headaches

Dermatologic

Rash	Dry or sensitive skin	

Psychiatric

Depressed mood	Trouble falling asleep	Trouble staying asleep
Anxiety	Frequent worried thoughts	Hallucinations
Loss of interest in work or home activities		