PREMIER SOUTH MEDICAL GROUP, P.C.

CONFIDENTIAL PATIENT INFORMATION SHEET

(PLEASE PRINT)

Date: ____/____/_____

PATIENT DATA:

PATIENT: (LAST NAME) _____ (FIRST) _____ (MI) ___

STREET ADDRESS: _____UNIT/APT#_____

CITY: _____ STATE: _____ COUNTY: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____EXT._____

CELL PHONE: (____) _____ SOCIAL SECURITY #: _____-_____-_____

DATE OF BIRTH: ____/____/_____ AGE: _____ SEX: ____ MALE ____FEMALE

MARITAL STATUS: ____SINGLE ____MARRIED ____DIVORCED ____SEPARATED ____WIDOWED

EMPLOYER'S NAME: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S NAME: _____ WORK PHONE: (____) _____ EXT: _____

SPOUSE'S EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: (LAST) _____ (FIRST) _____

RELATIONSHIP: _____ HOME PHONE: (____) _____

WORK PHONE: (____) _____ CELL PHONE: (____) _____

INSURANCE, PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPYING EACH VISIT.

PRIMARY INS. CO. NAME: _____ ID#:_____ GROUP#: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S SOCIAL SECURITY#:_____-_____-_____ POLICY HOLDER'S D.O.B: _____/_____/_____

SECONDARY INS. CO. NAME: _____ ID#: _____ GROUP#:_____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____-_____-_____ POLICY HOLDER'S D.O.B: _____/_____/_____

PLEASE LIST TWO NEAREST RELATIVES NOT LIVING WITH PATIENT

NAME (LAST) _____ (FIRST) _____ RELATIONSHIP: _____

HOME PHONE (____) _____ WORK PHONE: (____) _____ CELL PHONE: (____) _____

NAME (LAST) _____ (FIRST) _____ RELATIONSHIP: _____

HOME PHONE: (____) _____WORK PHONE: (____) _____ CELL PHONE: (____) _____

MEDICAL HISTORY

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

High Blood Pressure
Diabetes
Cancer
Heart disease
Chest pain/tightness
Shortness of breath
Swollen ankles
Palpitations
Lightheadedness
Frequent urination
Rheumatic Fever
Asthma
Bronchitis
Pneumonia
Persistent cough
TB
Hay fever
Abdominal discomfort

Indigestion
Nausea
Vomiting
Diarrhea
Constipation
Blood in stools
Ulcers
Change in bowel habits
Unexplained weight loss/gain
Hemorrhoids
Gall bladder disease
Colitis
Hepatitis or jaundice
Thyroid Disease
Head or neck radiation
Headache

Kidney disease
Difficulty urinating
Kidney stones
Arthritis
Low back problems
Skin disease
Blood disorder
Venereal disease
Anxiety
Depression
Anemia
Alcohol abuse
Drug abuse
Gout
_____
_____

EXPLAIN: _____

_____

_____

ALLERGIES TO MEDICATIONS, X-RAYS OR OTHER SUBSTANCES: _____NO _____YES
(If yes, please list names of medicines and/or type of reaction):

_____

_____

Please list the dates of:

Operations: _____

_____

Hospitalizations other than for surgery _____

_____

When was your last Cholesterol check? ___/___/___ When was your last Prostate exam? ___/___/___

When was your stool last checked for blood? ___/___/___

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of period: ___ Frequency: _____ Date of last period: ___/___/___ Length of period: _____

Number of pregnancies: ____ Number of births: ____ Number of miscarriages: ____

Method of birth control: _____

Prolonged or abnormal bleeding: ___No ___Yes (please describe): _____

Leakage of urine: ___No ___Yes (please describe): _____

Pelvic Pain: ___No ___Yes (please describe): _____

Abnormal discharge: ___ No ___Yes (please describe): _____

History of abnormal Pap smears: ___ No ___ Yes (Please describe): _____

Date of last Pap smear: ___/___/____ Date of last Breast Exam: ___/___/___

Date of last Mammogram: ___/___/___

IMMUNIZATION HISTORY (have you had):

Tetanus immunization: ___No ___Yes when: ___/___/___
Hepatitis B: ___No ___Yes when: ___/___/___
Flu Vaccine: ___No ___Yes when: ___/___/___
Pneumovax : ___ No ___Yes when: ___/___/___

I _____ have been requested by Premier South Medical Group, P.C. to supply my immunization records. I understand that my immunization records are necessary to assist you in keeping my records up to date and accurate.

Signature: _____ (signature of patient or legal guardian)

FAMILY HISTORY

Has any family member (to include parents, grandparents, and siblings) ever had the following?

ILLNESS	WHICH FAMILY MEMBERS	APPROX. AGE(S) WHEN DIAGNOSED
Cancer (type)	_____	_____
Hypertension (high blood pressure	_____	_____
Heart disease	_____	_____
Drug or Alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Mental disease (anxiety, Depression, etc.)	_____	_____
Other	_____	_____

LIST MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, HERBS and VITAMINS.)

DRUG NAME	DOSE	DRUG NAME	DOSE
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

PREVENTION

Do you smoke?	___No ___Yes	How many packs per day? ___
Do you drink? alcohol	___No ___Yes	How many per week? ___
Do you drink coffee?	___No ___Yes	How many cups per day? ___
Do you drink tea?	___No ___Yes	How many cups per day? ___
Do you use drugs (marijuana, cocaine, etc.)	___No ___Yes	
Do you wish to be tested for HIV/AIDS?	___ No___Yes	
Do you have a living will?	___ No___Yes	
Do you have a donor card?	___ No___Yes	

MEDICAL CONSENT * ASSIGNMENT OF BENEFITS * RELEASE OF INFORMATION

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE THE PHYSICIAN, PHYSICIAN ASSISTANTS, NURSE PRACTITIONER AND STAFF OF PREMIER SOUTH MEDICAL GROUP, P.C. TO PROVIDE MEDICAL CARE FOR THE PATIENT LISTED BELOW.

I ALSO AUTHORIZE PREMIER SOUTH MEDICAL GROUP, P.C., TO RELEASE ANY AND ALL MEDICAL INFORMATION NECESSARY TO PROCESS ANY AND ALL INSURANCE CLAIMS FILED BY PREMIER SOUTH MEDICAL GROUP, P.C. ON MY BEHALF.
I HEREBY ASSIGN AND AUTHORIZE WITH MY SIGNATURE MY INSURANCE CARRIER(S) TO MAKE PAYMENT DIRECTLY TO PREMIER SOUTH MEDICAL GROUP, P.C.

PATIENT NAME (LAST) _____ (FIRST) _____

HOME PHONE: (___) _____ WORK PHONE (____) _____ EXT: _____

CELL PHONE :(____) _____

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____

DATE: _____/_____/_____

PREMIER SOUTH MEDICAL GROUP, P.C. FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECKS, DEBIT, VISA, MASTER CARD AND AMERICAN EXPRESS.

IN ORDER FOR PREMIER SOUTH MEDICAL GROUP, P.C. TO HONOR YOUR INSURANCE BENEFITS, YOU MUST PROVIDE US WITH YOUR CURRENT/ACTIVE INSURANCE CARD EACH TIME YOU VISIT OUR OFFICE.

IF YOUR INSURANCE PLAN REQUIRES A PRIMARY CARE PHYSICIAN, OUR PHYSICIAN'S NAME MUST BE LISTED ON YOUR INSURANCE CARD. IF WE ARE NOT LISTED AS YOUR PRIMARY CARE PHYSICIAN, YOU MAY PAY FOR SERVICES OUT OF POCKET OR YOU MAY RESCHEDULE YOUR APPOINTMENT ONCE YOU HAVE CHOSEN ONE OF OUR PHYSICIANS AS YOUR PRIMARY CARE PROVIDER.

IF YOU BELONG TO A MANAGED CARE INSURANCE PLAN, ALL APPLICABLE FEES ARE DUE AT THE TIME OF SERVICE. PLEASE REFER TO YOUR INSURANCE PLAN.

IF YOUR INSURANCE COMPANY HAS A DEDUCTIBLE AND YOU HAVE NOT MET YOUR DEDUCTIBLE, YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES IS RENDERED.

OUR OFFICE SUBMITS OUR CLAIMS ELECTRONICALLY TO YOUR INSURANCE COMPANY WITHIN 24 HOURS OF YOUR VISIT. IN THE EVENT THERE WAS A MISCALCULATION IN COLLECTION OF YOUR CO-PAY, CO-INSURANCE OR DEDUCTIBLE ON YOUR DATE OF SERVICE, WE ASK THAT ONCE YOU RECEIVE YOUR EXPLANATION OF BENEFIT AND YOUR RESPONSIBILITY EXCEEDS WHAT YOU PAID AT YOUR VISIT, WE ASK THAT YOU PLEASE REMIT THE DIFFERENCE TO: PREMIER SOUTH MEDICAL GROUP, P.C., 3890 REDWINE ROAD, SUITE 200, ATLANTA, GEORGIA 30331.

WHEN YOU COME TO THE OFFICE FOR AN APPOINTMENT AND THERE IS A BALANCE ON YOUR ACCOUNT, WE WILL REQUIRE PAYMENT OF THAT BALANCE AT THE TIME OF SERVICE.

THERE WILL BE A $35.00 FEE FOR ANY CHECK OR DRAFT DISHONORED BY ANY FINANCIAL INSTITUTION.

IN THE EVENT PREMIER SOUTH MEDICAL GROUP, P.C., FINDS IT NECESSARY TO PLACE YOUR ACCOUNT WITH A COLLECTION AGENCY, YOU WILL BE CHARGED A FEE OF $25.00 IN ADDITION TO THE BALANCE OF YOUR ACCOUNT.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES RENDERED IN THE EVENT MY INSURANCE COMPANY DENIES PAYMENT IN FULL OR PART OF ANY SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO CO-PAYS, DEDUCTIBLE, NON-COVERED SERVICES AND SUPPLIES OBTAINED DURING THE COURSE OF MY CARE.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)
_____DATE: ____/____/_____