PATIENT REGISTRATION FORM

Date: _____ Preferred Pharmacy: _____ Pharmacy Phone: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON BEING SEEN TODAY.

Patient's First, Middle, Last Name: _____

Date of Birth: _____ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Patient's Next of Kin: _____ Relationship: _____ Date of Birth: _____

Next of Kin's Address: _____ Phone: _____

Race: ____ White/Caucasian _____ Black/African American _____ Asian ____ Decline_____ Other(explain): _____

Ethnicity: ____ Non-Hispanic/Non- Latino ____Hispanic/Latino ____Unknown ____Decline

Preferred Language: ____ English ____Spanish ____ Other: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR RELEASE OF MEDICAL INFORMATION.

□ I do not authorize any information to be released to anyone other than myself.

- **Do we have your permission to leave you messages on a voicemail? Yes / No**
- **Do we have your permission to discuss your medical condition with any member of your household? Yes / No**.

I hereby authorize my protected health information (ex: appointment information, results, medications) to be discussed with the following individuals. Name and Relationship:

1) **Name**: _____ Relationship: _____
2) **Name**: _____ Relationship: _____
3) **Name**: _____ Relationship: _____

PATIENT PORTAL REGISTRATION

The patient portal is available through Habersham Medical Center's website. **Through this portal the patient is able to view medication lists and discharge information, test results, message providers, as well as schedule appointments. If you are interested in signing up for the patient portal, please complete the form below.**

Patient's Name: _____ Date of Birth: _____

Email Address: _____

Please sign below authorizing temporary patient portal information to be sent to the above email address listed. ID must be presented at time of request. We cannot look up copies of ID that may be on file.

Signature: _____ Date: _____

PATIENT REGISTRATION FORM

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION FOR THE PATIENT.

Primary Insurance Carrier: _____ Subscriber's Name: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Carrier: _____ Subscriber's Name: _____

Policy Number: _____ Group Number: _____

PLEASE COMPLETE THE FOLLOWING FOR THE PERSON LISTED IN INSURANCE SUBSCRIBER ABOVE.

Responsible Person's Name (First, Middle Initial, Last): _____

Date of Birth: _____ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Social Security #: _____-_____-_____ Relationship to Pt: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PLEASE COMPLETE THE FOLLOWING MEDICAL PROVIDER INFORMATION

Please list all current and previous physicians (primary, referring, specialist) who follow you and your condition(s):

Provider: _____ Phone: _____ Fax#: _____

Provider: _____ Phone: _____ Fax#: _____

Provider: _____ Phone: _____ Fax#: _____

Provider: _____ Phone: _____ Fax#: _____

APPOINTMENT TIMES AND NO SHOWS

Dr. Nathaniel Hill and his staff strive to provide the best medical care. This is only made possible if our patients attend all scheduled appointments and follow all of the medical advice provided. Please understand:

- If the patient is more than 15 minutes late for their appointment, he/she will be asked to reschedule.
- If a patient does not show up for his/her appointment more than (3) times without calling to cancel Habersham Surgical Services will be obligated to release the patient from our care.

Patient Signature: _____ Date: _____

If patient is a minor, please have the legal guardian sign. Your signature acts as a consent to be treated.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties following the Notice: The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff, and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

- Treatment
- Payment
- Auditing
- Research
- Organ Donation
- Fundraising
- Health Care Operations
- Appointment Reminders
- Workers' Compensation
- Health oversight activities

As required by law
Lawsuits and disputes
Public health purposes
Activities of our affiliates
Law enforcement purposes
To military command authorities
National security and protective services
Too avert a serious and protective services
Too coroners, medical examiners, and funeral directors
Activities of managed care networks in which we participate

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories- Individuals involved in your care or payment.

Your Privacy Rights: You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health care.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of health information.

Change to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Hospital and Clinics.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Hospital Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT

Patient Acknowledgement: I acknowledge that I have received a copy of the Notice of Privacy Practices for Habersham Medical Center. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Time/Date: _____ Signature of Patient: _____

For use by Hospital Personnel Only: (Complete if patient acknowledgement has not been obtained) The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because: _____

Time/Date: _____ Signature of Hospital Representative: _____

Habersham Medical Group Surgical

MEDICAL HISTORY AND CURRENT SYMPTOMS

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY AND CURRENT SYMPTOMS

Patient's Name: _____ Pharmacy: _____ PCP: _____

Briefly explain the reason for coming to the clinic today: (List symptoms, duration, severity, and location):

_____

_____

Please list below all current medications with dosage (include over the counter and herbal medications)

_____

_____

_____

Please list any allergies you have and the reactions you experience:

_____

_____

Please list any surgeries you have had and the date of the procedures:

_____

_____

Have you had Cancer? Yes / No If Yes, please list the type and treatment: _____

Have you had a colonoscopy? Yes / No If Yes, when and where: _____ Polyps? Yes / No

Tobacco Use: Yes / No How many years? _____ Type_____ Quite Date_____

Alcohol Use: Yes / No How many years? _____ Type_____ Quite Date_____

PLEASE LIST HEALTH PROBLEMS WITHIN YOUR IMMEDIATE FAMILY HEALTH HISTORY

Father: _____

Mother: _____

Brother: _____

Sister: _____

Grandparent: _____

Habersham Medical Group Surgical

REVIEW OF SYMPTOMS

Date: _____ Patient's Name: _____ Referred by: _____

Reason for visit: _____

Preferred Pharmacy: _____ Primary Care Provider: _____

PLEASE CIRCLE ALL THAT APPLY TO THE PATIENT

Constitutional:	Appetite Change	Fever	Weight Gain	Fatigue
	Excessive Sweating	Night Sweats	Weight Loss	
Respiratory:	Cough	Shortness of Breath	Snoring	Coughing Blood
	Phlegm Production	Pain with Breathing	Apneas	
Cardiovascular:	Swollen Legs	Chest Pain		
Gastrointestinal:	Abdominal Pain	Vomiting	Constipation	Nausea
	Bloating	Trouble Swallowing	Diarrhea	Change in Bowel Habits
	Food Intolerance	Reflux/Heartburn	Black Stool	Bloody Stool
Urinary:	Change in Urinary Stream	Incontinence	Urinary Urgency	
	Painful Urination	Urinating at Night	Penile Discharge	
	Blood in Urine	Urinary Frequency	Sexual Dysfunction	
Skin:	Hair Changes	Pigment Changes	Rash	
	Lesions/Changes in Moles	Itching	Skin Changes	
Neurologic:	Abnormal Gait	Loss of Coordination	Seizures	
	Focal Weakness	Memory Problems	Slurred Speech	
	Headache	Numbness	Tremor	
Endocrine:	Excessive Thirst	Excessive Hunger	Excessive Urination	
Hematologic Lymphatic:	Bruising	Excessive Bleeding	Recurrent	Easy Bleeding
	Easy Bleeding	Enlarged Lymph Nodes		Infections
Allergic/Immunologic:		Eczema	Seasonal Allergies	Urticaria
Gynecological:	Painful Menstruation	Post-Menopausal	Nipple Discharge	