Endocrine Specialists of Athens
2470 Daniells Bridge Road, Bldg. 200 Ste. 221
Athens, GA 30606
Phone: 706-389-3180 Fax: 706-389-3181

Please Fill Out Completely:

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	Best way to contact (Circle one): Home Phone Cell Phone Email Letter

Employed by				
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	Address	City	State	Zip Code

Home Phone	Social Security	Date of Birth	Relationship to Patient

Employed by	Business Phone

Employer's Address	City	State	Zip Code

Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)	Daytime Phone

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____

_____

PHYSICIAN INFORMATION

Primary Care Physician _____

Address _____ Phone _____

Referring Physician (If different from Primary Care Physician) _____

Address _____ Phone _____

INSURANCE INFORMATION

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

_____ _____
Patient or Guardian Signature Date

ENDOCRINE SPECIALISTS OF ATHENS
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

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 Endocrine Specialists of Athens owned and operated by 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 Endocrine Specialists of Athens and St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

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Authorization for Release of Medical Information

Patient: _____ Date of Birth: _____
(First) (Last)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

☐ Complete Health Record (or check for certain sections)

☐ ER Record	☐ Surgical Pathology Report	☐ Nuclear Medicine Results
☐ History and Physical	☐ Cytology Results	☐ Thyroid US results
☐ Discharge Summary	☐ Most Recent Lab Work	☐ CT Scan Results
☐ Consultation Report	(CBC, CMP, Lipids, LFTs, A1c)	☐ MRI results
☐ Office Notes	☐ Thyroid cancer labs (Tg, TgAb, etc)	☐ Bone Density (DEXA)
☐ Operative Report		

☐ 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

_____ Date: _____/_____/_____
Printed Name of Legal Representative

If signed by Legal Representative please provide the following:
Relationship to patient: _____
Authority to sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney for Healthcare
☐ Other, Please describe: _____

Records may be faxed and/or mailed to the fax number and the address provided above.

Encodrine Specialists of Athens

Annual/New Medical History Intake Sheet

Patient Name:_____ Birth Date: ____/____/_____ Today's Date:_____

GENERAL HEALTH (circle) Excellent Good Fair Poor

Briefly state the main problem which prompted you to come. Include the length of time you have had it and associated history:

_____

_____

_____

_____

PAST MEDICAL HISTORY

Check conditions you have had:

- ☐ Abnormal EKG
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Asthma
- ☐ Breast Lump
- ☐ Cancer
  Type:_____
- ☐ Coronary Artery Disease (heart disease)
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Endocrine Disorder
- ☐ Gallbladder Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ High Cholesterol
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hypothyroidism (underactive thyroid)
- ☐ Impotence/Erectile Dysfunction
- ☐ Infertility
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Low Testosterone
- ☐ Mental illness
- ☐ Migraines
- ☐ Nipple discharge
- ☐ Osteoporosis
- ☐ Prior broken bones
- ☐ Pancreatitis
- ☐ Postmenopausal bleeding
- ☐ Seizures
- ☐ Serious injury
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Cancer
- ☐ Thyroid Nodule

Other Medical History: _____

Recent Hospitalizations:_____

PAST SURGICAL HISTORY: please list prior surgeries and year they occurred.

Type:_____ Date: _____

Type:_____ Date: _____

Type:_____ Date: _____

Type:_____ Date: _____

FAMILY MEDICAL HISTORY: include all known medical history including history of diabetes, hypertension, high cholesterol, thyroid disease and other endocrine disorders

	Age	Disease	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Children	____	_____	_____
	____	_____	_____

Endocrine Specialists of Athens

MEDICATIONS: please list all medications, supplements and herbal medications you take

Medication	Dose	How often?

Do you have any allergy to medications or foods?

ALLERGY	REACTION

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(ed)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_____

Use of Tobacco: ☐ Never ☐ Previous but quit ☐ Current packs per day _____

Use of Drugs: ☐ Never ☐ Type/frequency _____

Occupation: _____

HEALTH MAINTAINENCE

Date of last eye exam_____

Date of Pneumovax _____

Date of Last Flu Shot_____

Form of regular exercise? ☐ No ☐ Yes

If yes, what type and how often_____

Endocrine Specialists of Athens

Patient Name:_____

Check all that apply, leave blank if not applicable.
In the last year, have you had any of the following symptoms?

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Change in Weight of More Than 10 lbs

Eyes:
- ☐ Double Vision
- ☐ Blurred Vision

ENT:
- ☐ Changes in Hearing
- ☐ Hoarseness
- ☐ Voice Change

Cardiovascular:
- ☐ Chest Pain
- ☐ Racing/Skipping Heart Beats (Palpitations)
- ☐ Dizziness Getting Out of Bed or Using the Bathroom
- ☐ Loss of Consciousness

Pulmonary:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Snoring

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Difficulty Swallowing

Musculoskeletal:
- ☐ Joint Pain
- ☐ Muscle Aches

Dermatologic:
- ☐ Dry skin
- ☐ Rash
- ☐ Acne
- ☐ Hair Growth Change

Hematological/Lymph:
- ☐ Swollen Lymph Nodes
- ☐ Easy Bleeding
- ☐ Easy Bruising

General Genitourinary:
- ☐ Painful Urination
- ☐ Trouble Starting Urination
- ☐ Frequent Urination at Night

Male Genitourinary:
- ☐ Difficulty with Erections
- ☐ Lumps in Testicles or Scrotum

Female Genitourinary
- ☐ Irregular Menstrual Cycles
- ☐ Very Heavy Bleeding
- ☐ Very Light Bleeding
- ☐ Age Menses (Periods) Began _____
- ☐ First day of Last Menstrual Cycle (Date) _____
- ☐ Currently Pregnant
- ☐ Planning pregnancy in the near future
- ☐ Do you use any form of birth control
- ☐ Currently Breastfeeding

Neurological:
- ☐ Headaches
- ☐ Tremors
- ☐ Loss of Balance and/or Falling
- ☐ Numbness or Tingling
- ☐ Memory Loss

Psychiatric:
- ☐ Anxiety
- ☐ Depressed
- ☐ Suicidal

Endocrine:
- ☐ Colder Than Everyone Else
- ☐ Hotter Than Everyone Else
- ☐ Hot Flashes
- ☐ Excessive Urination
- ☐ Drinking More Fluids
- ☐ Decreased libido
- ☐ Nipple Discharge

Allergy/Immunology:
- ☐ Sinus Allergy
- ☐ Hay Fever

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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 Endocrine Specialists of Athens 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