980 Johnson Ferry Road NE
Suite 490
Atlanta, GA 30342
Phone: 404-254-3160
Fax: 404-254-3270

NORTHSIDE HOSPITAL

Southeastern Neurosurgical Specialists

English - Spanish

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German
☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Name of Policy Holder		
Date of Birth of Policy Holder		
Policy/Member ID Number		
Group/Plan Number		
Phone Number		
Effective Date of Policy		

Patient/Guarantor Signature _____ **Date** _____

Reorder #26985 PP0001 (SNS_B)
Piedmont Graphics 02/19/16

PATIENT REGISTRATION FORM

980 Johnson Ferry Road NE
Suite 490
Atlanta, GA 30342
Phone: 404-254-3160
Fax: 404-254-3270

NORTHSIDE HOSPITAL

Southeastern Neurosurgical Specialists

Patient Name _____

Date of Birth _____ / _____ / _____
Month Day Year

English - Spanish

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ **I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.**

_____ **I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues**

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

Reorder #26703 PP0004 (SNS_B)
Piedmont Graphics Rev. 05/27/16

ANNUAL ACKNOWLEDGEMENT

NORTHSIDE HOSPITAL

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at one or more Northside Hospital affiliated medical practices ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to each Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. Each Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to a Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Privacy, Individuals Involved In My Care. I understand that, unless I request confidentiality, the privacy laws allow the hospital to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with you.

Telemedicine I consent to telemedicine consultations as recommended by my physician. My medical information may be discussed with Georgia licensed health professionals through telecommunication technology and, in some cases, a physical examination will be performed. A non-medical technician may be present to assist with the technology and, unless I object, audio or video recordings may be taken during the consultation. I can withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any Medicaid benefits to which you would otherwise be entitled. If I do not consent to a telemedicine consultation, some services may not be available at all Northside locations. All state and federal laws, including privacy and confidentiality, apply to records of the telemedicine consultation.

PHOTOGRAPHY AND RECORDING. Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice; The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and if a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

Witness	Date	Time	Signature of Patient or Legal representative	Date	Time
Interpreter (Note: if phone interpretation used, record interpreter ID#)			Relationship to patient	reason patient can't sign	

NOTICE OF NON-DISCRIMINATION

Northside Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 404-845- 5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)

Northside Hospital cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee).

Northside Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

SOUTHEASTERN NEUROSURGICAL SPECIALISTS

MEDICATION AGREEMENT

Please don't wait until the last minute to request medications. It is YOUR responsibility to keep up with your prescriptions.

Please expect a 24-48 hour turnaround time for a medication request to be sent to your pharmacy.

1. Requests for medications made after NOON on Friday will not be addressed until that following Monday. The on-call doctor will not refill routine or controlled medications after hours during the week or at any time on weekends.

2. We cannot refill medications ordered by another physician. This includes medications for high blood pressure, diabetes, thyroid dysfunction, etc.

3. The new FDA/DEA law does not allow us to call in any narcotics and most other controlled substances. They will only be dispensed during clinic visits.

4. Refills will not be given to patients who have not been recently seen. This will be determined by the physician.

5. New prescriptions will not be given for lost or stolen narcotics or other controlled substances.

6. When calling for a medication, you will need to leave us your NAME, Date of Birth, Allergies, Pharmacy name and number, and a number where you can be reached.

7. Please be aware that all correspondence on the Athena Patient Portal, email, voicemail or fax is only checked Monday through Friday 8:30am to 4:00pm

8. Only one physician should be prescribing your medications

Please sign and date below to indicate that you understand and agree with the above statements.

_____ _____

Patient signature or representative Date

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Fax: 404-254-3270

NORTHSIDE HOSPITAL

Southeastern Neurosurgical Specialists

English - Spanish

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date: _____

As a patient, you have the option to designate a spouse, family members, friends, or other persons with whom this practice can communicate with about your health care status. It will be necessary to complete a new form at each Northside medical practice where you receive care. While this form is not required in all circumstances for your doctor or others at Northside to be able to communicate with your family about your health care, designating certain individuals who you want to be informed about your care on this form will ensure that your provider can speak with those people whom you have designated below.

If you anticipate that you will need or want your health information to be verbally provided to your family members, friends or caregivers, please indicate that below so that we may best serve you. By signing below, you authorize the following persons to receive your verbal health information as requested, regarding your care and treatment. Updates to this form must be made in person. Signing this form is entirely voluntary and optional. This form does not authorize release of copies of your health records.

First and Last Name	Relationship:

I understand that this Consent can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified at the top of this form. I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing or sign a new form.

_____ _____

Signature of Patient or Legal representative Print name:

_____ AM/PM _____ _____

Date Time Relationship to patient:

_____ _____

Interpreter (if applicable) Reason patient unable to sign:

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

Please complete this form and return it to the Practice manager.

FOR INTERNAL PURPOSES ONLY:

Date Consent Received: _____

Reorder #26700 PP0033 (SNS_B)
Piedmont Graphics Rev. 01/24/17

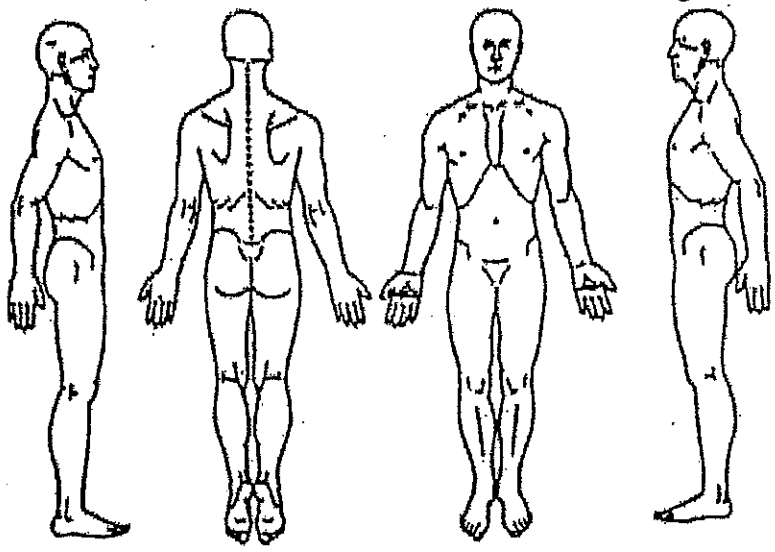
NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

Original - Medical Records
Yellow - Patient

SOUTHEASTERN
NEUROSURGICAL
SPECIALISTS

Name:_____

Please Indicate pain with X's and Numbness with O's on diagram below:



When did your symptoms start?_____

Describe your pain:		What aggravates your pain:		What improves your pain:				What treatments have you tried:	
Aching	☐	Bending	☐	Nothing	☐	Massage therapy	☐	Nothing	☐
Dull	☐	Twisting	☐	Ice	☐	Physical therapy	☐	Physical therapy	☐
Sharp	☐	Lifting	☐	Heat	☐	Chiropractic	☐	Massage therapy	☐
Shooting	☐	Sitting	☐	Sitting	☐	Pain management injections	☐	Chiropractic	☐
Stabbing	☐	Standing	☐	Lying down	☐	OTC NASAID's (Advil, Aleve)	☐	Name of Chiropractor:	
Burning	☐	Walking	☐	Stretching	☐	Acetaminophen	☐		
Stiffness	☐	Running	☐	Changing positions	☐	Prescription NSAIDs	☐	Pain management injections	☐
Other:		Coughing/Sneezing	☐	Exercise	☐	Narcotic paid medication	☐	Name of Pain Management doctor:	
		Lying flat	☐	Rest	☐				
		Changing positions	☐	Other:				Acupuncture	☐
		Other:						Aquatic therapy	☐
								Other:	

Please put a X beside **worst** area of pain. Please also indicate what level your pain is at its best; on average most of the time and at its worst using 0-10.
0 is no pain and **10** is the worst pain you can imagine

	X	Best	Average	Worst	Any other Comments?
Neck					
Left Arm					
Right Arm					
Both Arms					
Upper Back					
Lower Back					
Left Leg					
Right Let					
Both Legs					

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Reorder #PP0654 (SNS_B)
Piedmont Graphics 00/00/00

PAIN QUESTIONNAIRE

SOUTHEASTERN NEUROSURGICAL SPECIALISTS

Medical History

Full name:_____ Date of birth:_____ Date:_____

Primary doctor:_____

Doctor who requested today's visit:_____

List current/previous doctors and their specialty:_____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

_____

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ☐ Alcohol/Drug addiction
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer (type):
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ _____
- ☐ Crohn's disease
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis B or C
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Seizure
- ☐ Sexually transmitted disease (type):
  _____
- ☐ Sickle cell disease
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ (Positive) TB skin test
- ☐ Ulcerative colitis
- ☐ Other:_____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ☐ Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			
Sons and Daughters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No How often? How many drinks?

Do you smoke? ☐ Yes ☐ No Packs per day: ☐ ¼ pack ☐ 1½ packs How many years?_____

Are you a former smoke? ☐ Yes ☐ No ☐ ½ pack ☐ 2 packs Year quit?_____

Do you chew tobacco? ☐ Yes ☐ No ☐ 1 pack ☐ Other:_____

Do you use recreational/illegal drugs? ☐ Yes ☐ No

Have you worked with asbestos or other hazardous materials? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No Healthcare proxy? ☐ Yes ☐ No If so, who?

Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:_____ Last pap smear:_____ Last mammogram:_____

Last colonoscopy:_____ Last prostate cancer screening:_____ Last bone density scan:_____

Immunizations: ☐ Pneumovax:_____ ☐ Flu:_____ ☐ Tetanus:_____ ☐ Hep A:_____ ☐ Hep B:_____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats
- ☐ Weakness
- ☐ Fatigue
- ☐ Insomnia
- ☐ Change in hearing
- ☐ Change in vision
- ☐ Runny nose
- ☐ Nose bleed
- ☐ Fever
- ☐ Blood in sputum
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Chest discomfort
- ☐ Palpitations
- ☐ Fainting
- ☐ Change in exercise tolerance
- ☐ Difficulty swallowing
- ☐ Indigestion or heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habit
- ☐ Blood in vomit
- ☐ Blood in stool
- ☐ Difficulty urinating
- ☐ Trouble holding urine
- ☐ Frequency of urination
- ☐ Penis discharge
- ☐ Vaginal discharge/bleeding
- ☐ Nipple discharge
- ☐ Breast pain
- ☐ Breast lump
- ☐ Pain with intercourse
- ☐ Feeling too hot
- ☐ Feeling too cold
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness/Tingling
- ☐ Tremor
- ☐ Uncontrollable mood swings
- ☐ Anxiety
- ☐ Depression
- ☐ Skin Rash
- ☐ Back pain
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Other:_____

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

Patient/Designee signature _____ Patient name (PRINT) _____ Date _____ Time _____

Relationship to patient _____ Reason patient is unable to sign _____

125842P Rev. 08/13