A Northside Network Provider

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.

We require a minimum of 24 hour notice for cancellations. Failure to do so may result in a charge for the missed appointment.

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		
Policy Holder Name and Date of Birth		
Policy Holder Relationship to Patient		
Policy/Member ID Number		
Group/Plan Number		

Patient/Guarantor Signature _____ **Date** _____

Reorder #26985 PP0001
Piedmont Graphics Rev. 04/04/19

PATIENT REGISTRATION FORM

A Northside Network Provider

English - Spanish

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

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
Piedmont Graphics Rev. 04/02/19

ANNUAL ACKNOWLEDGEMENT

A Northside Network Provider

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 THIS MEDICAL PRACTICE OR ANY OTHER Northside Network Provider ("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 midlevel 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 or foreign objects removed, expelled or otherwise separated from my body. If tissue specimens include products of conception or fetal remains, they may be disposed of by the lab after necessary examination. 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. If tissue specimens include products of conception or fetal remains, they may be disposed of by the lab after necessary examination. 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 the 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 me.

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 my right to future care or treatment, or risking the loss or withdrawal of any Medicaid benefits to which I would otherwise be entitled. If I do not consent to a telemedicine consultation, some services may not be available at all Northside Network Provider offices. 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 at Network Provider offices 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

A Northside Network Provider

English - Spanish - French - Korean - Simplified Chinese - Vietnamese

[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____ Date: _____

Federal law allows a health care provider to discuss your health information related to your care or payment for your care with your family members and close personal friends who are involved in your care if you authorize us to do so. This form allows you to designate family members, friends or others with whom the practice listed above can share your health information and communicate with about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to discuss your health information with the individuals that you have listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form authorizes the practice to verbally communicate with the individuals you have listed below but does not entitle them to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Electing not to complete this form will not impact your care provided at this practice.

This form can be revoked by submitting a written request to the physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you expressly revoke it in writing. Completing a new Consent to Communicate form or electronically changing your communication preferences does not revoke any previous Consent to Communicate forms that you have completed, which the Practice may continue to rely on unless you elect to revoke the form.

First and Last Name	Relationship	Phone Number

_____ _____

Witness' Signature Date/Time Signature of Patient or Legal Representative Date/Time

_____ _____

Print Witness' Name Relationship to Patient If Not the Patient

_____ _____

Interpreter's Signature Date/Time Reason Patient Unable to Sign

Note: If remote interpretation used (phone/iPad), record interpreter name, ID#

Interpreter Comments (optional): _____

_____

Please complete this form and return it to the Practice

NORTHSIDE HOSPITAL PHYSICIAN OFFICE PRACTICE
CONSENT TO COMMUNICATE WITH DESIGNATED INDIVIDUALS

A Northside Network Provider

English - Spanish

Patient Name: _____ Date of Birth: _____

Physician: _____ Practice Name: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Your Physician has prescribed a treatment plan that includes the use of Controlled Substances, such as opioids (narcotic analgesics), benzodiazepines and barbiturate sedatives. These drugs have a potential for misuse and are therefore controlled by local, state and federal governments. Your treatment plan may include narcotics, intended to reduce the intensity of pain and improve your quality of life, or stimulants given for ADD or ADHD. The narcotic medications are not expected to provide complete pain relief or cure your pain. In order to provide the best quality of care, it is critical for you to be compliant with your treatment program. This agreement is a tool to protect both you, your Physician, and the Practice by establishing guidelines, within the laws, for proper Controlled Substance use.

By signing below, you agree to the following:

1. All Controlled Substances must come from a Physician at the Practice named above unless specific authorization is obtained for an exception. Multiple sources of Controlled Substances or failure to take the medications as prescribed can lead to adverse interactions, overdose, or death.
2. All Controlled Substances must be obtained at the ONE PHARMACY, identified above. Should the need arise to change your pharmacy, the Practice must be informed immediately.
3. The prescribing Physician or his/her delegate has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability. There may be random audits to confirm that you are not receiving Controlled Substances from other sources.
4. No substances with alcohol or illicit substances (marijuana, cocaine, heroin, amphetamines, ecstasy, PCP, etc.) may be used by you, while undergoing medication treatment by the Practice without prior approval from your Physician.
5. You shall take Controlled Substances as prescribed and instructed by your practitioner, unless you develop side effects. If you develop side effects, you must consult with your practitioner or local emergency providers. Any new medications, medical conditions, or adverse reactions to the prescribed medications must be disclosed to the Practice, clinical staff, and providers.
6. You may not share, sell, or otherwise permit others to have access to Controlled Substances prescribed by the Practice physicians. Since the medications may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, you must keep then secured from such persons. Diversion of Controlled Substances will result in dismissal from the Practice.
7. Medications prescribed by Practice physicians should not be stopped abruptly, as this may cause withdrawal symptoms.
8. Urine, serum (blood), or oral fluid (saliva) drug screens, and periodic confirmation testing is required by the Georgia Medical Board to identify compliance with prescribed medication(s) and your treatment plan. Failure to participate may result in immediate dismissal from the Practice.
9. Medications prescribed by the Practice physicians in original containers with remaining doses (pills, capsules, patches, creams, etc.) must be brought to each appointment for the purposes of accountability.
10. Your Physician will prescribe the medication he/she decides is appropriate for your clinical status; he/she is not under any obligation to prescribe any specific medication. Your Physician can wean you off pain medications at any time he/she feels that it is in your best interest.
11. If there is an acute problem (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), then another doctor may prescribe pain medications to you, but you will advise the prescribing doctor of your care at the Practice and will also notify your Physician of the medication and dosage.
12. Lost, stolen, or destroyed prescriptions will not be replaced.
13. You must agree to safe disposal of unused medications.
14. If legal authorities have questions concerning your treatment, confidentiality is waived and the authorities will be given full access to Practice records, as allowed by law.
15. You agree that Controlled Substance prescriptions, if medically necessary, will be provided on appointment days only. You understand that medication refills or adjustments are done only during office visits. Prescriptions will not be filled early, after normal business hours, on nights and weekends, or over the telephone. An exception may be made at the discretion of your Physician under unusual circumstances. You agree to be seen regularly and keep your appointments. Failure to keep appointments may result in discontinuation of Controlled Substances.
16. You are aware that your Physician will periodically check the Prescription Drug Monitoring Program. You agree to fill any additional forms during your office visits that may be required for risk assessment and compliance monitoring.
17. Practice physicians will not tolerate any disrespectful, abusive or aggressive language, or behavior toward any Practice staff members. Such behavior will result in discharge from the Practice.
18. You must exercise extreme caution when taking Controlled Substances and driving or operating heavy or complex machinery. These medications can cause drowsiness, confusion, or change your mental state and thinking abilities, thereby making it unsafe to drive or operate heavy machinery. If you are the slightest bit impaired, and there is any question of your ability to safely perform these activities, then you must refrain from doing so.
19. You understand that failure to abide by this Agreement may result in discontinuation of treatment and/or discharge from the Practice.
20. You understand that there is a risk you may become addicted to the Controlled Substances you are being prescribed. Your Physician may require you to see a specialist in addiction medicine should a concern about addiction arise.

_____ _____

Witness' Signature Date/Time

Signature of Patient or Legal Representative Date/Time

_____ _____

Print Witness' Name

Relationship to Patient If Not the Patient

_____ _____

Interpreter's Signature Date/Time

Reason Patient Unable to Sign

Note: If remote interpretation used (phone/iPad), record interpreter name, ID#

Interpreter Comments (optional): _____

_____

Reorder #28592 PP0091
Piedmont Graphics Rev. 01/06/2025

CONTROLLED SUBSTANCES/OPIOID PAIN AGREEMENT

RECORDING CONSENT FORM-CLINICAL DOCUMENTATION

To support our mission of providing the highest quality care, we are using a technology that uses artificial intelligence and associated workflows to generate documentation based on recorded audio of patient visits. The recorded audio is used to generate documentation for your medical records. The audio recording is destroyed once the documentation is finalized and reviewed by your provider. This technology significantly reduces the amount of time your provider spends on documentation and allows him or her to spend more time with you and other patients. We use a third-party service to process the recorded audio and we have appropriate agreements in place to safeguard the confidentiality of your information. To ensure the accuracy and completeness of your medical record, all documentation is reviewed, edited where necessary, and approved by your provider prior to finalization.

Please sign below to indicate your consent to have your visit recorded and processed for the purpose of documenting your care. This consent is voluntary. Declining to proceed with an audio recording of your visit does not prevent you from proceeding with your care. If consent is not provided, the practice will proceed without utilizing the recording technology.

* * *

_____

Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient If Not the Patient

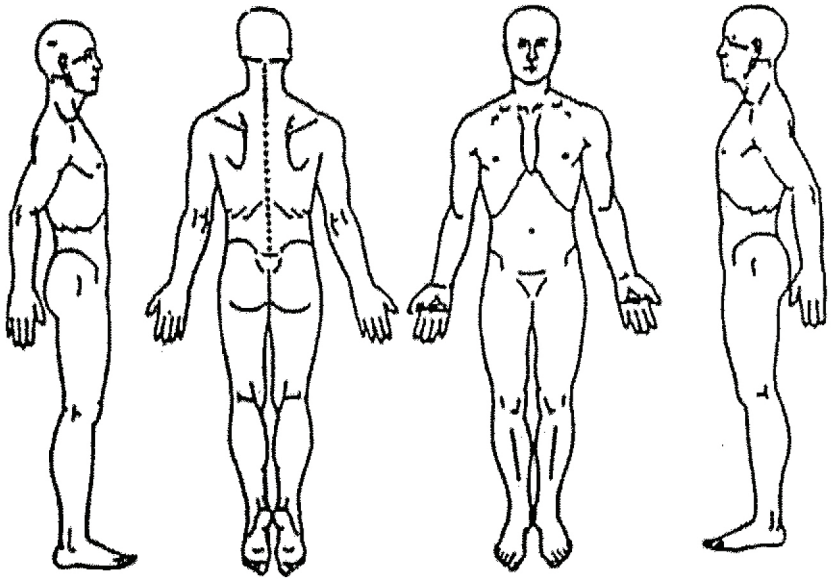
_____

Reason Patient Unable to Sign

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					

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

Reorder #46086 PP0654 (SNS_B)
Piedmont Graphics 11/12/18

PAIN QUESTIONNAIRE

SOUTHEASTERN NEUROSURGICAL SPECIALISTS

Patient Name_____ Patient Date of Birth: _____

Have you had the flu vaccine?_____ If so, when? (Approx. Month & Year) _____

Have you had the pneumonia vaccine?_____ If so, when? (Approx. Month & Year) _____

PAST MEDICAL HISTORY (Place 'X' in the box next to conditions you currently have or have had diagnosed in the past)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Cataracts
- ☐ Chest Pain
- ☐ Dental Infection
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis _____
- ☐ HIV Positive
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Incontinence/Bladder
- ☐ Kidney Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Seizure Disorder
- ☐ Substance Abuse
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid – Hypo
- ☐ Thyroid – Hyper
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other _____

Medication Allergies: _____

Are you allergic to: Adhesive Tape ☐ No ☐ Yes Latex ☐ No ☐ Yes Contrast Dye ☐ No ☐ Yes

CURRENT MEDICATION (Please list on this form)

Name of Medication	Reason	Dose	Frequency

PAST SURGERY HISTORY

Surgery Procedure	Surgery Date	Facility where performed

Have you had surgical complications? ☐ No ☐ Yes If yes, describe: _____

Tobacco Use:

☐ Never

☐ Yes How long? _____ Form of tobacco? _____ How much per day? _____

☐ Previously How long? _____ Form of tobacco? _____ When did you stop? _____

Alcohol Use: ☐ Never ☐ Occasional / Social _____ ☐ Other _____

Have you ever been treated for any type of alcohol or drug abuse dependency? ☐ No ☐ Yes

If yes please specify: _____

Patient Signature: _____ Date: _____

PATIENT INTAKE FORM

Patient Name_____ Patient Date of Birth: _____

FAMILY HISTORY (Please list any major medical problems and/or causes of death in your immediate family.)

Father	Mother	Children	Siblings	Grandparents

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 colonscopy: _____ 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 swing
- ☐ Anxiety
- ☐ Depression
- ☐ Skin Rash
- ☐ Back pain
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Other _____

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

1. _____

2. _____

3. _____

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

Relationship to patient _____ Reason patient is unable to sign _____

PATIENT INTAKE FORM