Infectious Disease Specialists of Athens
1500 Oglethorpe Ave, Suite 300B
Athens, GA 30606
Phone: (706) 559-4405
Fax: (706) 559-4773

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

Person responsible for payment	Relationship to pt	Address	Phone Number

Insurance Policy Holder Name	DOB	Address	Policy holder SSN

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

INFECTIOUS DISEASE 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 Infectious Disease 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 Infectious Disease Specialists of Athens and St. Mary's Health Care System, Inc.

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

Infectious Disease Specialists of Athens
1500 Oglethorpe Ave, Suite 500A
Athens, GA 30606
Phone: (706) 559-4405
Fax: (706) 559-4773

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	☐ Office Notes	☐ Echocardiogram Results
☐ History and Physical	☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)	☐ Nuclear Stress Test Results
☐ Discharge Summary		☐ CT Scan Results
☐ Consultation Report	☐ EKG	☐ Carotid-Vascular Study Results
☐ Operative Report	☐ Chest X-Ray Report	☐ Other as Specified_____
☐ Nursing Documentation	☐ Exercise Stress Test Results _____	

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.

Infectious Disease Specialists of Athens
St. Mary's Medical Group

Annual/New Medical History Intake Sheet

Patient Name:_____ Birth Date: ____/____/_____ Date:_____

Describe your main problem today: _____ Allergies: _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

What other things happen with this problem? _____

_____

List previous hospitalizations/surgeries/serious injuries and when?

_____

_____

Date of last: Mammogram _____

Colonoscopy _____

Pneumovax _____

Monthly self breast exam? ☐ No ☐ Yes
Form of regular exercise? ☐ No ☐ Yes _____
Seat belt use? ☐ No ☐ Yes

Social History:

Martial 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_____

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Occupation: _____

Have you ever had the following?

Thyroid disease …….	yes	no
Diabetes …….....	yes	no
Hypertension ……	yes	no
Cancer …….....	yes	no
Stroke ……	yes	no
Heart trouble …….	yes	no
Arthritis or gout ……	yes	no
Convulsions ……..	yes	no
Bleeding Tendency ……...	yes	no
Acute infections …….	yes	no
Sexually transmitted disease …	yes	no
Hereditary defects ……	yes	no

List medications you are currently taking including nonprescription or herbals

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

10)_____

Family Medical History:

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

Infectious Disease Specialists of Athens

St. Mary's Medical Group

PATIENT INFORMATION FORM

NAME: _____ DATE: _____

Please list any conditions or chronic illnesses you have (such as high blood pressure, diabetes, pregnancy, glaucoma, prostate problems, etc.)

_____ _____

_____ _____

_____ _____

☐ NONE

Please list allergies or reactions to food or medications:

_____ _____

_____ _____

_____ _____

☐ NONE

Please list all medicines or drugs being taken now that were prescribed by a doctor or dentist. (Include what you take for chronic conditions, birth control, etc.)

_____ _____

_____ _____

_____ _____

☐ NONE

Please list all medicines or drugs you sometimes take that were bought WITHOUT a PRESCRIPTION (such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins, etc)

_____ _____

_____ _____

_____ _____

☐ NONE

Do you (please circle one for each question)
Smoke? Often Sometimes Never
Drink Alcoholic Beverages? Often Sometimes Never

BE SURE YOU UNDERSTAND YOUR DOCTOR'S INSTRUCTIONS BEFORE YOU LEAVE THE OFFICE.

Infectious Disease Specialists of Athens
St. Mary's Medical Group

lease mark any of the following symptoms you have had in the last 3 months.

Patient Name:_____ Date:_____

GENERAL

Fever	NO	YES
Chills	NO	YES
Change in Appetite	NO	YES
Fatigue	NO	YES
Weight loss	NO	YES
Weight gain	NO	YES

EYES

double vision	NO	YES
blurred vision	NO	YES
change in vision	NO	YES

ENT

Ear Pain	NO	YES
Decreased hearing	NO	YES
Difficulty swallowing	NO	YES
Sore throat	NO	YES
Voice Change	NO	YES
Sinus problems	NO	YES

CARDIOVASCULAR

Chest pain or Discomfort	NO	YES
Racing/skipping heart beats	NO	YES
Shortness of breath with exertion	NO	YES
Swelling -feet,ankles, hands	NO	YES
Leg pain with exertion	NO	YES
Varicose Veins	NO	YES

RESPIRATORY

Sleep disturbance due to breathing	NO	YES
Cough	NO	YES
Shortness of breath	NO	YES
Wheezing	NO	YES
Excessive Snoring	NO	YES

FEMALE

Breast Pain	NO	YES
Breast Lump	NO	YES
Breast discharge	NO	YES
Pain with periods	NO	YES
Irregular periods	NO	YES
Vaginal discharge	NO	YES

GASTROINTESTINAL

Indigestion/heartburn	NO	YES
Nausea	NO	YES
Vomiting	NO	YES
Abdominal Pain	NO	YES
Diarrhea	NO	YES
Change in bowel habits	NO	YES
Dark tarry stools	NO	YES
Bloody stools	NO	YES

GENITOURINARY

Dysuria	NO	YES
Hematuria	NO	YES
Urinary Frequency	NO	YES
Urinary Hesitancy	NO	YES
Nocturia	NO	YES
Incontinence	NO	YES
Decreased Libido	NO	YES
Erectile dysfunction	NO	YES
Testicular pain	NO	YES

MUSCULOSKELETAL

Joint Pain	NO	YES
Joint Swelling	NO	YES
Muscle Aches	NO	YES

DERMATOLOGIC

Suspicious lesions	NO	YES
Itching	NO	YES
Rash	NO	YES
Dry skin	NO	YES

NEUROLOGICAL

Difficulty with concentration	NO	YES
Headaches	NO	YES
Falling Down	NO	YES
Weakness	NO	YES
Tremors	NO	YES
Memory Loss	NO	YES
Numbness/tingling	NO	YES
Lightheadedness	NO	YES
Vertigo	NO	YES

PSYCHIATRIC

Anxiety	NO	YES
Depression	NO	YES
Sleep Problems	NO	YES

ENDOCRINE

Cold Intolerance	NO	YES
Heat Intolerance	NO	YES
Excessive Urination	NO	YES
Excessive thirst	NO	YES

HEMETOLOGICAL

Enlarged Lymph Nodes	NO	YES
Bleeding	NO	YES
Abnormal bruising	NO	YES
Anemia	NO	YES

ALLERGY

Food Allergies	NO	YES
Year-Round Allergies	NO	YES
Hives or Rash	NO	YES
Seasonal Allergies	NO	YES

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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 Infectious Disease 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