Today's Date	**NEW PATIENT INFORMATION SHEET**	Single ❑	Widowed ❑
Name:	Date of Birth:	Married ❑	Separated ❑
Years in High School:	Years in College: Degrees:	Divorced ❑	
Occupation:	Birthplace:		

HISTORY OF THE PRESENT ILLNESS – Please answer all questions	**ALLERGIES**		
Where is your problem:	Are you allergic to:		
How long have you had this problem:	Penicillin, Sulfa, Antibiotics	❑ Yes	❑ No
What makes this better or worse:	Codeine or Morphine	❑ Yes	❑ No
How severe is your problem:	Aspirin	❑ Yes	❑ No
Any other signs and symptoms:	Insect Bites/Stings	❑ Yes	❑ No
When does this bother you more:	Any Foods:	❑ Yes	❑ No
What were you doing when you noticed this problem:	Any Medications:	❑ Yes	❑ No
Describe any discharge or odor:	List:		

Family History	**Age**	**Relatives Living. Is there health (Good or Poor)**	**Age at Death**	**Cause of Death**
Father				
Mother				
1. Brother/Sister				
2. Brother/Sister				
3. Brother/Sister				
4. Brother/Sister				
Spouse				
1. Son/Daughter				
2. Son/Daughter				
3. Son/Daughter				
4. Son/Daughter				

Has any blood relative or husband or wife ever had:	**Check if yes**	**Relationship if yes**
Allergies	❑	
Asthma	❑	
Arthritis	❑	
Birth Defects	❑	
Cancer	❑	
Depression/Emotional Prob.	❑	
Diabetes	❑	
Glaucoma	❑	
Heart Trouble	❑	
High Blood Pressure	❑	
Kidney Trouble	❑	
Mental Retardation	❑	
Sickle Cell Anemia	❑	
Stroke Epilepsy/Seizures	❑	
Substance Abuse	❑	
Suicide	❑	
Tuberculosis	❑	

DATE OF YOUR LAST PHYSICAL:		Physician:

HOSPITALIZATIONS: List all, for illness or surgery, beginning with the most recent

Date	Reason	Hospital	Physician

LIST ANY MEDICATIONS YOU TAKE:	

DIAGNOSTIC TESTING – WHEN WAS YOUR LAST			
Pap Smear:		EKG:	
Mammogram:		Stool Test (blood):	
Cholesterol:		Sigmoidoscopy:	

SOCIAL HISTORY – Answer All Sections	
Weight Now:	Do you use seat belts:
1 Year Ago:	**TOBACCO**
Desired:	Cigarettes: Packs/day:
ALCOHOLIC BEVERAGES	Cigars: Pipe:
Never:	Age started smoking:
Less than 6 drinks/week:	Age stopped smoking:
7-24 drinks/week:	Snuff:
Over 24 drinks/week:	Chewing Tobacco:
Treated for alcoholism?	**DIET**
Treated for drug dependency?	Any special diet:
Outcome of either treatment:	
	EXERCISE
	Type:

REVIEW OF SYSTEMS – Answer all questions

URINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Male – does regular testicle exams	No	Yes
Male – have you had a prostate exam	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female – on birth control	No	Yes
Female – vaginal infection in past	No	Yes
Female – have you had abnormal PAP	No	Yes

SKIN

Rash or itching	No	Yes
Do you do regular breast exams	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

CONSTITUTIONAL

Good general health lately	No	Yes
Recent weight change	No	Yes
Headaches	No	Yes

EYES

Wear glasses/contact lens	No	Yes

ENT

Sinus problems	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat changes	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Frequent coughing	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements/constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

ENDOCRINE

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Numbness or tingling sensations	No	Yes

PSYCHIATRIC

Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

OTHER COMMENTS:

IMMUNIZATIONS			YEAR
Rubella	Yes	No	
Measles / Mumps	Yes	No	
Tetanus	Yes	No	
Polio	Yes	No	
Diphtheria	Yes	No	
Influenza	Yes	No	
Hemophilius Influenza	Yes	No	
Pneumonia	Yes	No	
Hepatitis	Yes	No	
Current Immunizations	Yes	No	

PREGNANCIES	ANSWERS
How many total children	
How many children born alive	
How many stillborn	
How many premature	
How many C-sections	
Haw many miscarriages	
How many abortions	

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Patient Name:_____ DOB:_____

Preferred Pharmacy Name and City:_____

Pharmacy Phone:_____Drug Allergies:_____

Name of Medication	Strength	How often do you take it
Example: Prilosec	20 mg	Twice a day

West Georgia
Family Medicine PC

Terry Langford, D.O., DABFP

Patient Name _____ Male __Female__

Social Security Number____/____/____ Date of Birth____/____/____

Marital Status: Single __Married __Separated __Divorced __Widowed__

Mailing Address_____

City_____ State_____ Zip Code_____

Email address:_____

Home Phone Number (____)-____-____ Cell (____)-____-_____

Phone Number to call with results (___)-____-_____

Ok to leave a message? Yes__ No__

Emergency Contact_____ Phone (____)-____-____

Emergency Contact is: Legal Guardian__ Spouse__ Caregiver __

Insurance Coverage_____

Policy Holder Name_____Date of Birth __/__/____

Insurance Preferred Laboratory_____

I authorize West Georgia Family Medicine to release any information regarding my examination and treatment for the purpose of: obtaining insurance reimbursement, pre-certification, or medical referral. I authorize payment of medical benefits to West Georgia Family Medicine when claim forms are filed upon my behalf for treatment of a procedure. I also give my permission for medical treatment to the patient, if a minor. I understand and agree that I am responsible for the balance of my account for services rendered. Delinquent accounts will be submitted to a collection agency with an additional 30% added to the balance. I certify that the listed information is true and correct to the best of my knowledge and will accept the responsibility to provide the proper notification in the event of a change.

Is today's visit a yearly preventative physical? Yes__ No__

Patient Signature_____Date__/__/____

West Georgia
Family Medicine PC

Terry Langford, D.O., DABFP

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

NAME_____BIRTHDATE_____

SOCIAL SECURITY _____

I UNDERSTAND THAT AS PART OF MY HEALTH CARE, THIS ORGANIZATION ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSIS, TREATMENT AND ANY PLANS FOR FUTURE CARE AND TREATMENT.

I UNDERSTAND THIS INFORMATION SERVES AS:

1. A BASIS FOR PLANNING MY CARE AND TREATMENT
2. A MEANS OF COMMUNICATION AMONG THE HEALTH CARE PROFESSIONALS WHO CONTRIBUTE TO MY CARE.
3. A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND SURGICAL INFORMATION TO MY BILL.
4. A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED.

I UNDERSTAND THAT I HAVE THE RIGHT:

1. TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES.
2. TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED
3. TO REVOKE THIS CONSENT IN WRITING, WITH THE EXCEPTION OF BILLING (IF INSURANCE IS BILLED) AND REFERRAL PURPOSES.

I AUTHORIZE THE FOLLOWING TO HAVE ACCESS TO MY HEALTH INFORMATION:

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

I REQUEST THE FOLLOWING RESTRICTIONS OF MY HEALTH CARE INFORMATION.

_____

_____

SIGNATURE OF PATIENT DATE SIGNATURE OF WITNESS

West Georgia
Family Medicine PC

1899 Lake Road, Suite 212
Hiram, Georgia 30141
Phone: 770-222-5488
Fax: 770-222-5491

INSURANCE POLICY

IN ORDER TO ACCOMMODATE OUR PATIENTS REGARDING THEIR INSURANCE NEEDS, WE HAVE ENROLLED IN NUMEROUS INSURANCE PROGRAMS. WHILE WE ARE PLEASED TO FILE WITH CERTAIN CARRIERS ON YOUR BEHALF, IT IS IMPOSSIBLE FOR US TO KEEP TRACK OF ALL THE INDIVIDUAL REQUIREMENTS THESE PLANS MAY OFFER. EACH PLAN HAS DIFFERENT STIPULATIONS REGARDING POLICY.

IT IS YOUR RESPONSIBILITY TO READ AND UNDERSTAND YOUR OWN INSURANCE POLICY BEFORE SEEING THE DOCTOR. CERTAIN SERVICES AND PROCEDURES MAY NOT BE COVERED BY YOUR INSURANCE COMPANY, YOU MAY HAVE TO MEET A YEARLY DEDUCTIBLE.

IT IS YOUR RESPONSIBILITY TO PROVIDE THE CORRECT INSURANCE INFORMATION TO WEST GEORGIA FAMILY MEDICINE AND TO OBTAIN A REFERRAL IF YOUR INSURANCE PLAN REQUIRES YOU TO DO SO. IF YOU FAIL TO DO THIS, YOU WILL BE RESPONSIBLE FOR THE PAYMENT FOR SERVICES.

EVEN THOUGH YOU PAY A "CO-PAY", THIS DOES NOT MEAN THAT YOU WILL BE EXEMPT FROM PAYING ANY AMOUNT YOUR INSURANCE PLAN DOESN'T PAY. THERE ARE SOME PROCEDURES YOUR PLAN MAY NOT COVER SUCH AS ROUTINE PHYSICAL EXAMINATIONS, CERTAIN TYPES OF INJECTIONS, ETC. WHICH MAY NOT BE ELIGIBLE UNDER YOUR PLAN.

IN THE EVENT THAT:

A. YOUR INSURANCE COVERAGE DOESN'T PROVIDE BENEFITS BECAUSE WE ARE NOT PARTICIPATING PHYSICIANS ON YOUR PLAN.
B. YOUR INSURANCE COVERAGE IS NOT IN EFFECT ON THE DATE OF YOUR VISIT.
C. A NON-COVERED SERVICE IS PERFORMED OR ORDERED.
D. YOUR INSURANCE CARRIER DENIES PAYMENT FOR ANY REASON OTHER THAN STATED IN A, B, OR C ABOVE.

WE WILL BILL YOU DIRECTLY FOR ALL CHARGES RELATED TO YOUR OFFICE VISIT.

I HAVE READ THE OFFICE POLICY OF WEST GEORGIA FAMILY MEDICINE AS STATED ABOVE AND AGREE TO ACCEPT THE RESPONSIBILITY FOR MY ACCOUNT IN ACCORDANCE TO THE PROVISIONS ABOVE.

SIGNED: _____ DATE: _____