Candler Internal Medicine

106 Briarwood Rd.
Statesboro, Ga. 30458
Phone: 912-871-5000
Fax: 912-681-1444

380 Cedar Street
Metter, Ga. 30439
Phone: 912-685-3191
Fax: 912-685-3195

Personal Information

Name: _____ Date of Birth: _____ Social Security Number: _____

Race: _____ Gender: M F Marital Status: M S D W

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Alternative Contact Person: _____ Phone: _____

Employer: _____ Work Phone: _____

Spouse Name: _____ Date of Birth: _____ Spouse Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Information

Primary insurance: _____ Member Name: _____
Secondary Insurance: _____ Member Name: _____

Payment and Assignment of Insurance Benefits

- I agree to pay, at the time of service, any required co-payments, co-insurance, and deductibles, as well as charges for services not covered by my insurance.
- I understand that I am financially responsible for any balance not covered by my insurance and that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.
- I understand that there is a $35 charge for returned checks.
- I hereby authorize and direct payment of medical benefits to Candler Internal Medicine for services rendered by physician or nurse practitioner.
- I hereby authorize Candler Internal Medicine to release my protected health information (PHI), any medical or incidental information that may be necessary for medical care, in processing application for financial benefits, my insurance companies or other third party payers, including their representatives as necessary.
- I understand that there will be a $50 no show fee for appointments that are not cancelled 24 hours in advance.

You are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, you are hereby notified that your physician has ownership interest in East Georgia Regional Medical Center.

Patient Signature: _____ Date: _____

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Candler Internal Medicine Patient HIPPA Consent

Patient's Name: _____ **Date of Birth:** _____

I understand that the patient's health information is private and confidential. I understand that Candle Internal Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Candler Internal Medicine may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

I understand that Candler Internal Medicine utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPPA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.

Understand that Candler Internal Medicine utilizes an electronic prescribing mechanism for electronic transmission of prescription to my local Pharmacies and mail order pharmacies.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (Human Immunodeficiency Virus), Hepatitis B Virus, or Hepatitis C Virus, I consent to the testing of my blood and body fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed, as required by Georgia Law.

Candler Internal Medicine has a detailed document call "Notice of Privacy Practices" that contains more information about policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Candler Internal Medicine may update this "Notice of Privacy Practices". If I ask, Candler Internal Medicine will provide me with the most current "Notice of Privacy Practices". This notice is also in the waiting room.

My signature below indicates that I have been given the chance to review a current copy of Candler Internal Medicine's "Notice of Privacy Practices". My signature means that I agree to allow Candler Internal Medicine to use and disclose the patient's personal information to carry out treatment, payment, and health care operations.

Name of person signing: _____ Date: _____
Signature: _____ Relationship to Patient: _____
Relationship to patient id signed by anyone other than the patient (Parent, legal guardian or other authorized representative only)

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Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

To best contact number to reach me:

1. _____ Able to leave a detailed message with health information Yes No
2. _____ Able to leave a detailed message with health information Yes No

Many of our patients allow family members such as their spouse, parents or others call and request medical or billing information. Under the requirement of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form giving us permission to release your information. Information will only be released to individuals listed on this form.

I authorize Candler Internal Medicine to release my medical and/or billing information to the following individual(s)

1. _____ Relationship to patient_____ Contact number_____
2. _____ Relationship to patient_____ Contact number_____
3. _____ Relationship to patient_____ Contact number_____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any of the above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

What is the Reason for this Visit? _____

Allergies: _____

Preferred Pharmacy: _____

Past Medical History-These are any problems that you have had in the past

Ears, Eyes, Nose, Throat

Deafness	Yes	No
Other Hearing Problems	Yes	No
Blindness	Yes	No
Cataract	Yes	No
Glaucoma	Yes	No

Other Visual Problems: _____

Heart

Heart Attack	Yes	No
Congestive Heart Failure	Yes	No
Angina	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Cardiac Cath	Yes	No

Other Heart Problems_____

Stomach and Bowel

Stomach Ulcers	Yes	No
Colon Cancer	Yes	No
Liver Disease	Yes	No
Hepatitis	Yes	No
Irritable Bowel Syndrome	Yes	No

Other: _____

Nervous System

Stroke	Yes	No
Brain Injury	Yes	No
Nerve Injury	Yes	No
Memory Problems	Yes	No

Other: _____

Female

PCOS	Yes	No
Irregular Menstrual Period	Yes	No
Painful Intercourse	Yes	No

Lungs

Lung Disease	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Chronic Bronchitis	Yes	No
COPD	Yes	No
Tuberculosis	Yes	No
Lung Cancer	Yes	No
Pneumonia	Yes	No

Other: _____

Kidney and Genital

Kidney Failure	Yes	No
Dialysis	Yes	No
Prostate Problems	Yes	No
Venereal Disease	Yes	No

Other: _____

Muscle and Bone

Skin Disorder	Yes	No
Joint Disease	Yes	No
Rheumatoid Arthritis	Yes	No
Osteoarthritis	Yes	No
Broken Bones	Yes	No

Other: _____

Endocrine

Thyroid Disease	Yes	No
Diabetes	Yes	No
Adrenal Disease	Yes	No

Other: _____

Male

Erectile Dysfunction	Yes	No
Low Testosterone	Yes	No

Other Problems

HIV or AIDS	Yes	No	Gout	Yes	No
Psychiatric Disease	Yes	No	Hyperlipidemia	Yes	No
Anemia	Yes	No	Osteoporosis	Yes	No

Other: _____

Past Surgical History- Please list any surgeries that you have had (Include year and Hospital)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Past Hospitalization (Include reason, year, and Hospital)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Any History of Transfusions? (Blood, Platelets, Plasma) Yes No
Type: _____

Social History

Ethnic Background: African American White Latino Asian other: _____

Tobacco Use

Smoking Status: ____Everyday _____Occasional _____Former Smoker ____ Never Smoked
__Cigarettes __Cigars __Smokeless Tobacco __Pipes Packs Per Day: _____ second Hand Smoke: _____

Alcohol Use

__Never Used __Occasionally __1-3 per day __3 or more a day __Quit Using alcohol

Illicit Drugs

Have you ever used illegal or recreational drugs? _____ If Yes Describe: _____
Have you ever felt like you use too much alcohol or drugs? _____

Family History

Mother: Alive or Deceased Age: ____
Has your mother had any illness? If so List below.

_____
_____

Father: Alive or Deceased Age: _____
Has your father had any illness? If so list below

_____
_____

Siblings

Brothers
Number Alive Number Deceased
Any Illnesses: _____

Sisters
Number Alive Number Deceased
Any illnesses? _____

Children
Number of sons? _____ Ages: _____
Any illness? _____
_____

Number of Daughters? _____ Ages _____
Any illness? _____
_____