DR. B. ABRAHAM, P.C.

Demographic Registration Form

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Social Security Number (- -) | Occupation/Title/Position

Address (Street & Apt. # if applicable) | Employer | Address

City | State | Zip Code | City | State | Zip Code

Primary Phone ( ) - ❑Home ❑Cell ❑Work | Secondary Phone ( ) - ❑Home ❑Cell ❑Work | Other Phone ( ) -

Email | Preferred Method of Contact

Date of Birth (/ /) | Sex | Race | Mother's Maiden Name | Ethnicity (Hispanic/Latino) | Marital Status

Lives with: ❑ Spouse/Partner ❑ Children ❑ Other Adult/Sibling ❑ Nursing Home or Other Facility ❑ Assisted Living ❑ Alone ❑ Both Parents ❑ Mother ❑ Father ❑ Legal Guardian | Preferred Language

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

Full Name | Social Security Number (- -) | Relationship to Patient

Address (Street & Apt. # if applicable) | Employer | Address

City | State | Zip Code | City | State | Zip Code

Daytime Phone ( ) - | Cell/Alternate Number ( ) - | Date of Birth (/ /) | Sex

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

Mother's Full Name (including middle initial if applicable) | Father's Full Name (including middle initial if applicable)

Person to be contacted for appointments, results, etc. | Daytime Phone ( ) - | Cell/Alternate Number ( ) -

EMEREGENCY CONTACT—RESIDING AT DIFFERENT ADDRESS (i.e. Friend, relative outside of the home)

Full Name (including middle initial if applicable) | Relationship to Patient

Address (Street & Apt. # if applicable) | Daytime Phone ( ) - | Cell/Alternate Number ( ) -

City | State | Zip Code | **May we discuss personal health information with this person?** ❑ Yes (all info) ❑No (emergency contact notification only)

FINANCIAL INFORMATION (Please bring insurance cards and all other needed forms to every office visit.)

Primary Insurance:

Insurance Company Name | Medical Billing Phone # ( ) -

Medical Claim's Billing Address (Street & PO Box # if applicable)

City | State | Zip Code

Primary Policy Holder's Name | Relationship to Patient

Insured SSN (- -) | Employer | Insured Date of Birth (/ /)

Insurance Policy/ID Number | Insurance Group Number

Type of Insurance (Indicate all listed on card) ❑PPO ❑POS ❑HMO ❑Other: | Are we the PCP listed? ❑Yes ❑No ❑N/A

Secondary Insurance:

Insurance Company Name | Medical Billing Phone # ( ) -

Medical Claim's Billing Address (Street & PO Box # if applicable)

City | State | Zip Code

Secondary Policy Holder's Name | Relationship to Patient

Insured SSN (- -) | Employer | Insured Date of Birth (/ /)

Insurance Policy/ID Number | Insurance Group Number

Type of Insurance (Indicate all listed on card) ❑PPO ❑POS ❑HMO ❑Other: | Are we the PCP listed? ❑Yes ❑No ❑N/A

I authorize release of my medical records to my insurance company. I further authorize the company to submit payment to Dr. B. Abraham, P.C. for all services rendered to me in this office. I understand that payment is due at the time of service, including any co-pays and unmet deductibles based upon services rendered. Additionally, I authorize Dr. B. Abraham, P.C. to provide reasonable and proper medical care by today's standards. **Please remember, it is your responsibility to inform us of changes to your insurance, phone number, email, or address. Time is limited in filing claims correctly with insurance companies.**

Patient Consent: _____ **Date:** _____

DR. B. ABRAHAM, P.C.

Medical History Form

Patient Name: _____

Date of Birth: __/__/____ | Age: ____ | Today's Date: __/__/____

Home Phone: (___) ____-____ | Cell: (___) ____-____

Email: _____

Pharmacy Name/Phone: _____

Reason for Visit:

- ❑ Chronic Disease
- ❑ Physical
- ❑ Injury
- ❑ Sick/Illness

Specify reason for visit below is needed:

_____

MEDICINE ALLERGIES

(Describe Reaction)

_____

_____

_____

_____

_____

_____

_____

MEDICINES YOU ARE TAKING

(Bring all prescriptions, over-the-counter meds, vitamins, and birth control meds to all office visits.)

Med Name & Dose	Frequency Used	Med Name & Dose	Frequency Used

HOSPITALIZATIONS/SURGERIES

Year	Reason (i.e. Childbirth, Illness, Surgery, Injury	Hospital/Facility, State

HEALTHCARE PROVIDERS (within the last 5 years)

Year	Physician & Specialty (i.e. Dr. Smith, PCP)	Reason for visits

Immunizations (If the exact date is not known, please provide the year.)

Tetanus: __/__/____ Vaccine updated with Pertussis (TDaP)? _____

Flu Vaccine: __/__/____ HPV Vaccine: __/__/____

Pneumovax: __/__/____ Hepatitis B Vaccine: __/__/____

Shingles: __/__/____ History of Chicken Pox/Date: __/__/____

HISTORY (Female)

Are you Pregnant? Y / N

Planning Pregnancy? Y / N

# of Pregnancies: _____

# of Deliveries: _____

Miscarriages/Abortions: ___/___

Living Children: _____

Full Term/Pre Term: ___/___

Contraceptive Method: _____

Last Menstrual Period: _____

Last Pap Smear: _____

Result: _____

Last Mammogram: _____

Result: _____

Age of Menses: _____

Duration of Menses: _____

Age of Menopause: _____

HISTORY (All)

Last Routine EKG: _____

Result: _____

Last Stress Test: _____

Result: _____

Last Colonoscopy: _____

Result: _____

Last Routine Labs: _____

Cholesterol Value: _____

Last Routine Physical: _____

Last Bone Density: _____

Result: _____

HISTORY (Male)

Last Prostate Exam: _____

Result: _____

Last PSA Blood Test: _____

Result: _____

HEALTH PROBLEMS/SIGNIFICANT MEDICAL ISSUES

(Please check all applicable illnesses from your medical history and list the year of diagnosis in parenthesis.)

❑ Alcoholism (_____)
❑ Cancer (_____)
Type _____
❑ Drug Abuse (_____)
❑ High Cholesterol (_____)
❑ Lung Disease (_____)
❑ Stroke (_____)
❑ Anemia (_____)
❑ Depression (_____)
❑ Hypertension (_____)
❑ Mental Illness (_____)
❑ Thyroid Problem (_____)
❑ Arthritis (_____)
❑ Diabetes (_____)
Insulin Dependent? ___
Last A1C: _____
❑ Gout (_____)
❑ Kidney Disease (_____)
❑ Seizures (_____)
❑ Venereal Disease (_____)
❑ Asthma (_____)
❑ Heart Disease (_____)
❑ Liver Disease (_____)
❑ Stomach Ulcers (_____)

Provide additional comments noting any other significant medical issues: _____
_____

FAMILY HISTORY

(Please indicate as much relevant medical information known for your immediate family members listed below.)

Parents:

	Living	Deceased	Age/Age at Death	Health Problems
Father	❑	❑		
Mother	❑	❑		

Siblings:

# of Brothers:

Living	Deceased	Age	Health Problems
❑	❑		
❑	❑		
❑	❑		
❑	❑		

# of Sisters: _____

Living	Deceased	Age	Health Problems
❑	❑		
❑	❑		
❑	❑		
❑	❑		

Children:

# of Sons: _____

Living	Deceased	Age	Health Problems
❑	❑		
❑	❑		
❑	❑		
❑	❑		

# of Daughters: _____

Living	Deceased	Age	Health Problems
❑	❑		
❑	❑		
❑	❑		
❑	❑		

Grandparents:

	Living	Deceased	Age/Age at Death	Health Problems
Paternal Grandfather	❑	❑		
Paternal Grandmother	❑	❑		
Maternal Grandfather	❑	❑		
Maternal Grandmother	❑	❑		

SOCIAL HISTORY

❑ Single ❑ Married ❑ Divorced
❑ Widowed ❑ Living Together
Length of relationship status: _____
Education/Degree: _____
Current Employment: _____
Exercise Type: _____
Nutrition/Diet: _____
Vacation Frequency: _____

Tobacco Use: ❑ Never Used ❑ Chew/Dip Use ❑ Smoker
Quit? ___ years ago | Smoked for ___ years | Amount: ___ pks/day
# of Smokers in the household: ___
Alcohol use? ❑ Yes ❑ No | Amount: ___ drinks / ❑day ❑wk ❑mo
Caffeine: coffee/tea, etc. ____ cups / ❑ day ❑ wk
Street/illegal drug use: ❑ Yes ❑ No | Type/frequency: _____
Gun/Firearm in home: ❑ Yes ❑ No Fire Extinguisher: ❑ Yes ❑ No
Home Smoke Detectors: ❑ Yes ❑ No Use Seatbelt: ❑ Yes ❑ No

Please ✔ those you are currently experiencing and ✕ those you have experienced in the past year.

General
- ❑ Weight change
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever/chills
- ❑ Night sweats

Skin
- ❑ Skin, hair, and/or nail changes
- ❑ Itching/rashes
- ❑ Sores
- ❑ Lumps
- ❑ Moles
- ❑ Tattoos

Head
- ❑ Trauma
- ❑ Headaches
  Location: _____
  Frequency: _____
  Duration: _____
- ❑ Sound/light sensitivity

Eyes
- ❑ Glasses/contacts
- ❑ Blurriness
- ❑ Tearing
- ❑ Itching
- ❑ Visual changes
- ❑ Cataracts
- ❑ Glaucoma

Ears
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Vertigo
- ❑ Discharge
- ❑ Earache

Nose / Sinuses
- ❑ Runny/stuffy nose
- ❑ Sneezing
- ❑ Itching
- ❑ Allergy
- ❑ Bloody nose

Mouth / Throat / Neck
- ❑ Bleeding gums
- ❑ Dentures
- ❑ Hoarseness
- ❑ Sore throat
- ❑ Swollen neck

Breasts
- ❑ Skin changes
- ❑ Masses/lumps
- ❑ Pain
- ❑ Discharge

Pulmonary
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Sputum production
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Tuberculosis

Cardiovascular
- ❑ Hypertension
- ❑ Palpitations
- ❑ Chest pain
- ❑ Skipped heart beats
- ❑ High cholesterol
- ❑ Heart murmur
- ❑ Stroke

Gastrointestinal
- ❑ Appetite change
- ❑ Nausea/vomiting
- ❑ Vomiting blood
- ❑ Diarrhea
- ❑ Constipation
- ❑ Indigestion
- ❑ Tarry stools
- ❑ Bloody stools
- ❑ Hemorrhoids
- ❑ BM frequency
- ❑ Abdominal pain
- ❑ Jaundice
- ❑ Liver/pancreatic problems

Urinary
- ❑ Frequency
- ❑ Hesitancy
- ❑ Excessiveness
- ❑ Burning
- ❑ Bleeding
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Infections
- ❑ Dribbling
- ❑ Incomplete bladder emptying
- ❑ Night urination

Genital (Male)
- ❑ Penile discharge
- ❑ Sores
- ❑ Testicular pain/ masses
- ❑ Hernias
- ❑ Erectile dysfunction

Genital (Female)
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Itching
- ❑ Sores
- ❑ Hot flashes

Muscular Skeletal
- ❑ Weakness
- ❑ Pain
- ❑ Joint stiffness
- ❑ Joint instability
- ❑ Redness
- ❑ Swelling
- ❑ Arthritis
- ❑ Gout

Neurological
- ❑ Numbness/loss of sensation
- ❑ Tingling
- ❑ Tremors
- ❑ Weakness/paralysis
- ❑ Fainting/blackouts
- ❑ Seizures

Vascular
- ❑ Swelling
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Pain-walking

Hematology
- ❑ Anemia
- ❑ Easy bruising/ bleeding

Endocrine
- ❑ Heat/cold intolerance
- ❑ Excessive sweating
- ❑ Excessive urination
- ❑ Excessive hunger/ thirst
- ❑ Thyroid problem
- ❑ Diabetes
- ❑ High or low blood sugar

Psych
- ❑ Mood changes
- ❑ Anxiety
- ❑ Depression
- ❑ Memory Loss

DR. B. ABRAHAM, P.C. Notice of General Office Policies

Financial Policy

The only insurances we will file routinely are those HMO's, PPO's, Medicare, and Medicaid for which we are providers. The co-pay, deductible (if not met), and/or coinsurance are to be paid by the conclusion of the visit. For your convenience, we offer several ways to pay, including cash, check, Visa, MasterCard, and Discover. In the event that a balance goes unpaid for more than 90 days, your account may be subject to collection procedures. The patient will be responsible for all collection fees. The fees will be in addition to the outstanding balance.

Managed Care Insurers

In order to accommodate the needs of our patients, we have enrolled in many managed care insurance programs. We are pleased to be able to provide this service to you, but it is extremely difficult for us to keep track of all the individual requirements of the insurance plan.

Each one has different stipulations regarding how services may be rendered and, even more importantly, where those services may be performed. Even with the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service what those guidelines are.

1. If you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

2. In the event that services are provided and your coverage is not in effect on that day, then the fees submitted and denied by your carrier will become your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs. As your healthcare provider, our staff will always strive to give you the utmost in quality care, and we appreciate your cooperation in enforcing this policy.

Referral Policy

In order for us to provide quality care **we require 72 hours notice** for a referral along with any emergency room visit, hospital stay, and specialist notes. We are your primary care physicians and referrals will not be given without a visit with our office for that particular problem. The only exception is any life threatening situation. Sorry for any inconvenience this may cause. For further clarification please see our office staff.

No Show Policy

Failure to keep your appointment will result in a $25 no show charge. This is not a billable insurance charge; therefore, you will be liable for this fee. This will help us accommodate all of our patient's needs and provide you the utmost care.

Electronic Prescription Policy

Our office utilizes electronic prescriptions (e-prescriptions) when available. This allows our office to send the medication(s) prescribed to you during your office visit electronically to the pharmacy you have provided on your Medical History Form before you ever leave our office. It eliminates the need for paper prescriptions in most cases and saves you the trouble of having to drop off your prescription at the pharmacy. For more information regarding e-prescriptions, visit www.LearnAboutePrescriptions.com

DR. B. ABRAHAM, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices and Acknowledgement of Receipt of Notice of General Office Policies

I, _____, was provided with access to copies of and asked to read the **Notice of Privacy Practices** and **Notice of General Office Policies** for this office.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Patient's Full Legal Name

Mid Level Providers
This office uses Nurse Practitioners/Physician Assistants for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. I understand and am in agreement with being treated by a Nurse Practitioner/Physician Assistant, who is acting under the supervision of Dr. Abraham and Dr. Barrington, for minor illnesses and injuries.

_____ _____
Signature Date

External Prescription History
I authorize Dr. B. Abraham, P.C. and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff at Dr. B. Abraham, P.C., and it may include prescriptions from the past several years. My signature below certifies that I read and understand the scope of my consent and that I authorize access.

_____ _____
Signature Date

Study Department
With my consent, the study department of Dr. B. Abraham, P.C. may call my home/mobile phone and leave a message or mail information to my home (email or postal service) regarding studies which may be of interest and/or benefit to me.

_____
Initials

With my consent, the study department of Dr. B. Abraham, P.C. has my permission to enter demographic, medical, and/or insurance information into the study database for study use.

_____
Initials

If you have any questions regarding this notice of our health information privacy policies, please contact Dr. B. Abraham, P.C. at 770-978-1331.

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices and Notice of Office Policies, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (Please Specify): _____

_____
Employee's Initials

DR. B. ABRAHAM, P.C.

Authorization to Disclose Medical Information

It is our policy to contact you at your preferred method of contact. If we are unable to do so, we will attempt to reach you at any/all of the other numbers provided by you to our office. In addition to contacting you by phone, our office utilizes the patient portal (for more information regarding this or to set up you account, please see our front desk), email, and mail via the postal service. Please provide your preferred method of contact below as well as a list of any restrictions you may have regarding our office contacting you through the use of any of the methods listed above.

_____

Preferred Method of Contact

Restrictions

I, _____, authorize the following individuals listed below to receive any/all medically related information considered confidential in my medical record held at Dr. B. Abraham, P.C. This authorization is valid for 7 years from the signed date or until I formally revoke this authorization

Authorized Person(s):

Name	**Phone Number**	**Relationship**
	( ) -	
	( ) -	
	( ) -	
	( ) -	
	( ) -	

The above listed person(s) may request and discuss medically relevant results and information contained within my medical record as stated above. By signing below, I acknowledge that I have given all representatives of Dr. B. Abraham, P.C. permission to discuss this information.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Patient's Name