ANOINTED HANDS MEDICAL SERVICES
REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Email Address:	Social Security no.:	Home phone no.: ( )

Street Address	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate **primary insurance** ❑ Medicare ❑ Medicaid ❑ Other: (write in)

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of **secondary insurance** (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Anointed Hands Medical Services or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Consent for Medical Treatment

I Voluntarily present for treatment and consent to my physician and whomever they designate as their assistant associated, treating physician, and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiology evaluations and procedures considered advisable in my diagnosis, treatment and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations.

Authorization for release of information

I authorize Anointed Help Medical Services and its physicians or representatives to release to insurance companies, government agencies or their intermediaries, third party payor and physicians participating in my care, or their agents, any medical records or other information necessary to obtain payment for medical services provided to me; including medical, psychiatric, psychological school, vocational records of evaluation and/or treatment for physical and/or emotional illness including past history, diagnosis, complications and residuals, prognosis, progress notes, medications, workshops evaluations, training reports, IQ scores, treatment plans, recommendations, summaries, current status, evaluation and treatment records of alcohol or drug abuser, records of HTLV-3 or HIV testing (AIDS test) results , and AIDS treatment records. I request that anointed Help Medical services and its representatives submit all medical charges to insurance companies, government agencies or their intermediaries, third party payor, providing benefits to me.

Assignment of Benefits

In consideration of the medical services provided or to be provided by above mentioned Facility, I assign to Anointed Help medical services and its' physicians or physician representatives all rights which I have against insurance companies, government agencies or their intermediaries, or third party payors, for payment of charges for services provided or to be provided to Anointed Help Medical services or its physicians to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payor. I also understand that if my bill is paid in full, any additional funds received may be applied to other bills that are owed by me or one of my dependents. I further understand that any overpayment will be reviewed at my request and refunded to the appropriate payor.

Patient Pre- Certification Responsibility

I understand that I am responsible for notifying my insurance company to obtain authorization before service is provided if required by my insurance. I understand that if I do not pre-certify my treatment or obtain a referral prior to the first and all subsequent visits as required by my insurance, it might cause a reduction or loss of paid benefits to the provider for which I will be financially responsible.

Advance Beneficiary Notice (ABN)

We expect that Medicare will not for the Item(s) or service(s) that are described below. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. As us to explain if you don't understand why Medicare may not pay.

Medicare may not pay for these item(s) or
Service(s)_____

Reason:_____

Estimated
cost:_____

☐ Yes, I want to receive these items of services. I understand that Medicare may deny payment of these item(s) or service(s), and I agree to be responsible for payment.

☐No, I don't want to receive these items of service.

Patient Name (PRINT)_____

Patient Signature _____DATE___/___/____

Responsible party Signature _____Relationship_____ Date:___/___/___

ANOINTED HANDS MEDICAL SERVICES
Dr. Kenneth O'Neal ♦ Dr. Lorrie Richardson- O'Neal
1215-A Tuscany Drive
Braselton, GA 30517
PHONE: 770-307-1880 FAX: 770-307-1889

ORIGINAL DATE:
DATES REVISED:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	

MARITAL STATUS:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PREVIOUS OR REFERRING DOCTOR:		**DATE OF LAST PHYSICAL EXAM:**	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:				
	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

Please turn to next page

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

fAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Completed by _____ Relationship: ☐Self, Other: _____ Date ____/____/____

Reviewed by ☐Nurse☐ Dr: ._____ Date: ____/____/____

ANOINTED HANDS MEDICAL SERVICES

LORRIE RICHARDSON-O'NEAL MD
KENNETH O'NEAL MD

115 TOWNE CENTER PKWY
SUITE 114
HOSCHTON, GA 30548

P: 706-684-0588
F: 706-684-0753
ANOINTEDHANDS.NET

I acknowledge that there is a read-only Notice of Privacy Practices available at Anointed Hands, a digital copy on the website, anointedhands.net, and that I am also able to receive a hard copy upon request. I am expected to read, understand, and agree to the content of the Notice of Privacy Practices.

_____
Printed Name

_____ _____
Signature Date

For Minors Only:

_____
Name of minor

_____ _____
Signature of Parent or Legal Guardian Date

Authorization for Release of Patient Information

115 Towne Center Pkwy
Suite 114
Hoschton, GA 30548

P: 706-684-0588
F: 706-684-0753

AnointedHands.Net

Name **DOB**

Maiden Name **SSN**

I authorize the following person/organization to send/fax my medical records to Anointed Hands Medical Services:

Name

Address *Suite*

City *State* *Zip Code*

Telephone Number *Fax Number*

To disclose the above named individual's health information as described below, please provide the following information:

Date(s) of service requested (if known) or Provider _____

Description of Information to be released (check all that apply)

- ☐ Immunization records
- ☐ Most recent history and physical
- ☐ Laboratory reports
- ☐ Consultations
- ☐ Radiology/Imaging reports
- ☐ Progress notes
- ☐ Radiology Films
- ☐ Entire Medical Record
- ☐ Other_____

Description of the purpose of the use and/or disclosure

- ☐ Continuing Care
- ☐ Second Opinion
- ☐ Social Security/Disability
- ☐ Consultation
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other: Please Describe _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDs), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information. This information may be used by or sent to Anointed Hands Medical Services:

- ☐ Dr. Lorrie Richardson-O'Neal
- ☐ Dr. Kenneth O'Neal

I FULLY UNDERSTAND that my medical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or substance abuse information, and/or AIDs/HIV test results and/or information. Only records and or information believed necessary for the purpose expressed above should be released and disclosed. This release may NOT include hospital records OR records from another physician.

I understand that my refusal to consent to the release of the above mentioned information would prevent the disclosure of this information. I understand that if this authorization is for purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency, and if I refuse to authorize the release of information for this purpose, it may adversely affect my entitlement to insurance benefits.

I understand that I may revoke this authorization at any time except to the extent that this action has already been taken in reliance thereof. Authorization for release expires 90 days or ____/____/_____, unless I revoke it.

Signature of Patient or representative Date

Printed Name of Patient or representative Relationship to patient

**legal authority to represent: attach document if appropriate