Middle Georgia Chest and Medical Center

Patient Registration Form

Name_______________________________ Birthdate_______________
First Middle Last Month Day Year

Street Address______________________City______________ State____Zip_____

Home Phone #(___)___________ Cell Ph #(___)________Email_______________

Social Security Number_____________ Race_____Ethnicity: Hispanic Non/Hispanic

Name of Employer_______________________Occupation_____________________

Street Addresss________________________ Work Phone____________________

City____________________________ State_________ Zip Code______________

Marital Status: Single Married Divorced Widowed

Name of Spouse____________________Contact Number______________________

Emergency Contact__________________Contact Number______________________

Emergency Address____

Relation to Emergency Contact________________

PLEASE GIVE US A COPY OF ALL INSURANCE CARDS!

**I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and completed all the above answers to the best of my knowledge. I certify that all the information is true and correct. I will notify you of any changes in my status or the above information.

Signed______________________________ Date____________________________

Please circle admit or denies for any of the symptoms you have:

Sleep

Snoring (Admits / Denies), Excessive Daytime(Admits/Denies) Sleepiness (Admits / Denies) Fatigue (Admits / Denies), Insomnia (Admits / Denies), Gasping and Grunting at night (Admits / Denies), Morning Headaches (Admits / Denies)

General

Change in appetite (Admits / Denies), Fever (Admits / Denies), Chills (Admits / Denies)

Eyes

Blurred Vision (Admits / Denies), Discharge from eyes (Admits / Denies), Pain in eyes (Admits / Denies)

Ears, Nose and Throat

Dry Mouth (Admits / Denies), Sore Throat (Admits / Denies), Swollen glands (Admits /Denies)

Endocrine

Excessive hunger (Admits / Denies), Cold Intolerance (Admits / Denies), Excessive sweating (Admits / Denies), Excessive thirst (Admits/Denies), Heat Intolerance (Admits / Denies) Weight Loss (Admits / Denies)

Respiratory

Cough (Admits / Denies), Shortness of Breath (Admits / Denies), Shortness of Breath with exertion (Admits / Denies), Wheezing (Admits / Denies)

Cardiovascular

Fluttering of the heart (Admits / Denies), Chest Pain (Admits / Denies), Chest Pain with exertion (Admits / Denies), Dizziness (Admits / Denies), Fluid accumulation on the legs (Admits / Denies), Weakness (Admits / Denies)

Gastrointestinal

Abdominal Pain (Admits / Denies), Change in bowel habits (Admits / Denies), Decreased Appetite (Admits / Denies), Diarrhea (Admits / Denies), Nausea (Admits / Denies), Vomiting (Admits / Denies), Weight Loss (Admits / Denies)

Genitourinary

Blood in urine (Admits / Denies), Difficulty urinating (Admits / Denies), Frequent Urination (Admits / Denies), Painful urination (Admits / Denies), Painful urination (Admits / Denies)

Musculoskeletal

Painful joints (Admits / Denies), Swollen joints (Admits / Denies)

Skin

Dry Skin (Admits / Denies), Itching (Admits / Denies), Rash (Admits / Denies)

Neurologic

Balance difficulty (Admits / Denies), Dizziness (Admits / Denies), Fainting (Admits / Denies), Tingling/Numbness (Admits / Denies)

Middle Georgia Chest and Medical Center
New Patient Intake Form

Welcome to the Middle Georgia Chest & Medical Center. Our goal is to offer you the best health care experience possible in a friendly, professional environment. Please help us make your visit the best it can be by filling out the following questions.

Name________________________________ **Date:**__________________________

What is the reason for your visit today (for example, to establish care with a new doctor)? _
____
____
____

What medicines do you currently take? **PLEASE LIST ALL PRESCRIPTIONS, OVER THE COUNTER MEDS, AND HERBAL SUPPLEMENTS**

Name of Medicine	What dose do you take?	How Often Do You Take It?

Past Medical History:

Please list all medical problems that you have been diagnosed with by other doctors in the past or that you are taking medicines for at this time.

____
____
____
____
____
____

Have you had any Surgeries? If so, please list the surgery and what year you had it done.

____
____
____
____

Are you allergic to any medicines? If you are, please write what kind of reaction you had to that medicine.

____
____
____

Have you ever been admitted to the hospital in the past?

Date of Admission	Reason for admission?

Are there any medical problems (for example, heart attacks, strokes, diabetes, asthma, cancer, high blood pressure, kidney disease, high cholesterol, etc.) that run in your immediate family (Your mother, father, brothers, sisters, children, grandparents).

Relative	Medical Problems	Alive or Deceased?

Social History

Do you smoke or have you EVER smoked cigarettes or cigars? ______
What year did you start?____________________
When did you quit?__________________
How many packs a day did you/do you smoke? ___________________

Do you drink alcohol? ________________ How often?___________________

Have you ever used any illegal drugs? ________________________________

Middle Georgia Chest and Medical Center

Ram K. Puri, M.D., FACP, FCCP

"Helping Patients, One Breath at a Time . . ."

1209 Columbia Drive Milledgeville, GA 31061 (478) 452-3200 Fax: (478) 452-1515

Date___________________

I give Dr. Ram Puri's office permission to access my prescription history from my pharmacy. My current pharmacy is ____.

____

Signed

Middle Georgia Chest & Medical Center
1209 Columbia Drive
Milledgeville, GA 31061
(478)452-3200 Fax (478) 452-1515

Authorization for and Consent to Release Information

Patient Name____________________
Social Security #_________________
Date of Birth____________________

I, the undersigned patient/guardian, hereby authorize
__________________________to release information listed below from the records of______________________.

The release of information to which I consent is for the purpose of:____

____

For the following dates of hospitalization, outpatient services, or office notes or procedures:

____

____

____

________________________ Signature of Patient/Guardian

________________ Date

________________________ Relationship to Patient

________________ Signature of Witness

Middle Georgia Chest and Medical Center

STATEMENT OF FINANCIAL RESPONSIBILITY

Date

I hereby assume and agree to pay Dr. Puri for all services rendered by him to ________________________________ , and if this is not paid upon request, or in the event legal proceedings are instituted or become necessary in order to collect that debt or enforce this agreement, I agree to pay all costs incurred by Dr. Puri, MD, therewith including reasonable attorney's fees or any other collection costs incurred.

<u>AUTHORIZATION TO RELEASE INFORMATION</u>: I hereby authorize Dr. Puri, who has attended me to give the ________________________________ Insurance Company, or its representatives, any and all information, including history records, that may be deemed by the company.

<u>ASSIGNMENT OF INSURANCE BENEFITS</u>: I hereby authorize payment directly to the Doctor, Ram K. Puri, such payments as would otherwise be payable to me. I understand I am financially responsible to Dr. Ram K. Puri for charges not covered by this agreement.

Date :____________________ Signed ____

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

______________________________	______________________________	______________
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, ______________________________, *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):* ______________________________

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet,
"A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

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This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Notice of Information Practices

1. Middle Georgia Chest and Medical Center may use and disclose treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies, for claims including a coordination of benefits with other insurers, collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Middle Georgia Chest and Medical Center is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements of court order.

3. Middle Georgia Chest and Medical Center will not make any other use or disclose protected health information without individual's written consent or authorization. Such authorization may be revoked at any time. Revocation must be in writing.

4. Middle Georgia Chest and Medical Center may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the patient.

5. Middle Georgia Chest and Medical Center reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

6. Middle Georgia Chest and Medical Center will abide by the terms of this notice or the notice currently in effect at the time of disclosure.

7. Middle Georgia Chest and Medical Center will provide each patient a copy of any revision to its Notice of Information Practices at the time of his or her next visit, or at his or her known address if there is a need to disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

8. Any person/ patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice please contact the Practice and ask for the Privacy officer at the following phone number (478) 452-3200. All complaints will be addressed.

9. It is Middle Georgia Chest and Medical Center's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

I have received a copy of the Notice of Information Practices.

X______________________________