INFECTIOUS DISEASE SERVICES OF GEORGIA, P.C.

ROSWELL • CUMMING • JOHNS CREEK

REGISTRATION FORM

Information provided on this form is considered protected health information and is protected by Federal and State Privacy Regulations.

PLEASE PRINT

PATIENT INFORMATION

Today's Date:	Please Identify Your Primary or Preferred Language: ☐ English ☐ Other (Specify) ____________			
Last Name:	First Name:	Mid. In.:	☐Mr. ☐Mrs. ☐Miss ☐Ms.	Date of Birth:
Former Name:	Social Security No.:	Sex: ☐ M ☐ F	Marital Status: ☐Single ☐Married ☐Widow ☐Divorced ☐Separated	
Street Address:		Apt. No.		Home Phone:
City:		State:	Zip:	Cell Phone:
Occupation:	Employer:			Work Phone:

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other:

Used only to allow patient login to Electronic Record - Patient Portal
Email Address:

ENTER A SELECTION FOR BOTH RACE AND ETHNICITY

Race: (select one or more from the following)
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Decline

Ethnicity: (select one)
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino
- ☐ Decline

REFERRAL/PRIMARY CARE PHYSICIAN

Reason for Referral to this Clinic:

Referred to Clinic By: (check one)
☐ Clinician ☐ Physician ☐ Family Member ☐ Friend ☐ Other____________

If Referred by Physician – Physician's Name:		Phone:
Primary Care Physician (if different from above):	Office Location:	Phone:

INSURANCE INFORMATION

Insurance Company:	Effective Date:	Phone:
Policy Holder's Name:	Employer:	Date of Birth
Policy Number:	Group Number:	I.D.
Name of Secondary Insurance (if applicable): «InsuranceName1»	Effective Date:	Phone:
Secondary Ins. - Policy Holder's Name:	Employer:	Date of Birth
Secondary Ins. Policy Number:	Secondary Ins. Group Number:	Secondary Ins. I.D.

Continued

Patient Name:		Date of Birth:

PREFERRED PHARMACY

Pharmacy Name:	Phone Number:
Address:	City:

CURRENT TREATMENT

List the names of all current physicians and the treatment you are receiving.

Physician Name	Phone/Contact Info	Reason for Treatment

Do you have an Advanced Directive? ___yes ___no If yes, please provide a copy for your health record.
Check all that apply: ___Do Not Resuscitate ___Living Will ___Power of Attorney

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Phone:	2nd Phone:

AUTHORIZATION FOR TREATMENT

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated provider.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to Infectious Disease Services of Georgia, P.C. for services covered by insurance or other health benefit plans.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Infectious Disease Services of Georgia, P.C. to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV/AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom I have been referred for healthcare services or who provides consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of this authorization is as valid as the original.

______________________________ ______________________

Patient/Guardian Signature Date

____

Relationship if Other than Patient

Patient Name: ______________________________ DOB: _______________

INFECTIOUS DISEASE SERVICES OF GEORGIA, P.C.

ROSWELL • CUMMING • JOHNS CREEK

Michael P. Dailey, M.D.
David L. Dickensheets, M. D.
Ayesha A. Faruqi, M.D.
M. Rabiul Alam, M.D.
Titu D. Das, M.D.
Manuel D. Rodriguez, D.O.

E-PRESCRIBE AUTHORIZATION

As part of the Electronic Medical Record, Infectious Disease Services of Georgia, P.C. (IDSGA) uses the Surescripts Network to fill prescriptions electronically (e-prescribe). E-prescribe services include:

Core Services – E-Prescribing New Prescriptions and Refills
E-Prescribing allows the doctor's office to electronically send an accurate, comprehensive, error-free prescription directly to a pharmacy.

Prescription Benefit (Formulary/Benefit)
Gives the doctor's office information about which drugs are covered by your drug benefit plan.

Medication History
Provides information about your current and past prescriptions and informs the doctor's office of potential medication concerns.

Medication history includes information about medications prescribed by IDSGA as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, sexually transmitted diseases, substance abuse, genetic diseases, and HIV/AIDS.

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By signing this consent form, I agree that Infectious Disease Services of Georgia, P.C. may request and use my prescription medication history from Surescripts Medication Network Services for treatment purposes.

I understand that refusal to authorize the use of e-prescription services will not affect my ability to receive treatment, payment, enrollment or eligibility for benefits and may not be the basis for denial of health care services.

I also understand that this authorization does not protect medical information that is released to another health care provider.

This authorization will remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of this authorization is as valid as the original.

____ ______________________
Patient/Guardian Signature Date

____
Relationship if Other than Patient

Patient Name: _______________________________ DOB: _______________

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PATIENT'S INSURANCE OBLIGATION

In order to accommodate the needs and requests of our patients, we have contracted with numerous managed care companies. By doing so, we agree to file your insurance claim in a timely manner and to accept a discounted fee for service, in addition to fulfilling other contractual obligations. It is your responsibility to contact your insurance company to verify that we are on your particular plan.

We rely on you to give us the correct insurance information needed to file your claim properly. For this reason, we will ask you to present a copy of your insurance card at every visit. You will receive an explanation of benefits (EOB) from your insurance company when your claim is processed. This should take no longer than 30 days, but some insurance companies delay up to 90 days. Please review the EOB and if you find any errors, i.e., processed out of network or denied for lack of referral, please contact your insurance company first and then notify our business office. If you do not receive an EOB within 60-90 days, you should contact your insurance company to verify that they are indeed processing your claim. The #1 response we receive when we status an insurance claim is that the claim is not on file. We can assure you that we file the claim within days of your office visit.

In addition, it is impossible for us to know all the individual requirements unique to the specific contract your employer has made with your insurance company. Some contracts exclude particular lab tests, require you to use a specific lab for blood work, deny screening tests or wellness visits, or require precertification for particular x-rays. You can only help yourself by becoming as familiar as possible with your benefits. You need to know your particular insurance plan. By becoming an informed consumer and assuming an active role in your healthcare, you can prevent unexpected personal expenses.

In the event that a non-covered service is performed, we will expect that you personally assume responsibility for payment of your medical care.

I ______________________________ have read this insurance statement and agree to accept
(print name)
responsibility as described above.

______________________________ ______________________

Patient/Guardian Signature | Date

____

Relationship if Other than Patient

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I ____________________ have received a copy of Infectious Disease Services
(print name)

of Georgia, P.C. Notice of Privacy Practices.

Print Name: ____
(Please Print)

Signature: ____

Date: ____

FOR OFFICE USE ONLY

On ______________ at_________ Infectious Disease Services of Georgia, P.C. staff made a good faith attempt to obtain a written acknowledgement of receipt of Infectious Disease Services of Georgia, P.C. Notice of Privacy Practices, but acknowledgement could not be obtained because of the following reason:

(check items that apply)

_____ Patient refused to sign

_____ Communication barriers prevented obtaining a receipt

_____ An emergency prevented obtaining a receipt

_____ Other:

____
(Describe)

Staff Signature: ________________________ Date: ____________________

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COMPREHENSIVE PATIENT HISTORY

Patient Name: ______________________ Date of Birth: __________ Date ______________

What is the reason for today's visit? ______________________________

Describe the Following:

Location: ______________ How long have you had this problem? ______________

How severe is this problem? ☐ mild ☐ moderate ☐ very How often are you having the problem? __________

What caused the problem? ______________________________

Do you know of anything else that may have contributed to this problem? ______________

Does anything else occur with this problem? ______________________________

Provider Comments: ☐ I have confirmed the above information with the patient. Additional comments:

List previous hospitalizations/Surgeries/Serious Injuries	Date

Describe Current Tobacco Use: ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Smoker – Status Unknown ☐ Former Smoker ☐ Never Smoker ☐ Unknown if Ever Smoked

Describe Alcohol Use: ☐ Never Use ☐ Monthly Use or Less ☐ 2 to 4 Times per Month ☐ 2 to 3 Times per Week ☐ 4 or More Times per Week ☐ Daily Use

Use of Drugs: ☐ Never Use Currently use the following Drugs:
☐ Daily Use ☐ Monthly Use or Less ☐ 2 - 3 times a Month
☐ 2 - 3 times per Week ☐ 4 or more times per week

Excessive Exposure At Home or Work To: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Have you ever had the following?			Diabetes……………….	yes	no	Hypertension…………	yes	no
Cancer…………………	yes	no	Stroke………………….	yes	no	Heart trouble…………..	yes	no
Arthritis/Gout………….	yes	no	Convulsions……………	yes	no	Bleeding Tendency……..	yes	no
Acute Infections………..	yes	no	Venereal Disease……….	yes	no	Hereditary Defects……..	yes	no

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

CURRENT MEDICATION

List all medication that you are currently taking – including "Over-The-Counter" [OTC] medication(s).
Request additional paper if needed to complete list.

Medication	Check One	Dosage and Frequency	Reason Taken	(If Prescription Medication) Prescribed by
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
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	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			
	Prescription ☐ OTC ☐			

MEDICATION ALLERGIES

Have you ever had an allergic reaction to medication: ☐ Yes ☐ No ☐Check if allergic to more than 8 meds

If "yes" -- List all medications and describe the allergic reaction you experienced below.

Name of Medication : Describe Reaction:

1. ______________________ ______________________________________
2. ______________________ ______________________________________
3. ______________________ ______________________________________
4. ______________________ ______________________________________
5. ______________________ ______________________________________
6. ______________________ ______________________________________

OTHER ALLERGIES

List any OTHER allergies that you have:

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________
5. ______________________________ 6. ______________________________
7. ______________________________ 8. ______________________________

Have you recently experienced any of the following?

PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL			Date
Good general health lately……………………..	No	Yes	
Recent weight change………………………….	No	Yes	
Fever………………………………………...	No	Yes	
Fatigue……………………………………….	No	Yes	
Headaches…………………………………...	No	Yes	
EYES			
Eye disease or injury…………………………..	No	Yes	
Wear glasses/contact lens……………………..	No	Yes	
Blurred or double vision………………………	No	Yes	
Glaucoma…………………………………...	No	Yes	
ENT			
Hearing loss………………………………...	No	Yes	
Ringing in the ears…………………………….	No	Yes	
Earaches or drainage…………………………..	No	Yes	
Sinus problems……………………………...	No	Yes	
Nose bleeds……………………………………	No	Yes	
Mouth sores……………………………………	No	Yes	
Bleeding gums…………………………………	No	Yes	
Bad breath or bad taste………………………...	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	
Spitting up blood……………………………….	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 or constipation……	No	Yes	
Blood in stool…………………………………..	No	Yes	
Stomach pain……………………………………	No	Yes	
GENITOURINARY			
Frequent urination………………………………	No	Yes	
Burning or painful urination……………………	No	Yes	
Blood in urine…………………………………..	No	Yes	
Change of force of strain when urinating……	No	Yes	
Incontinence or dribbling……………………….	No	Yes	
Kidney stones…………………………………..	No	Yes	
Male – testicle pain……………………………..	No	Yes	
Female – pain with periods……………………..	No	Yes	
Female – irregular periods………………………	No	Yes	
Female – vaginal discharge……………………..	No	Yes	

Female – # pregnancies _____ # miscarriages ______
Female – date of last pap smear __________________
Female – findings of last pap smear __ Normal __ Abnormal

MUSCULOSKELETAL			Date
Joint pain……………….………………………	No	Yes	
Joint stiffness or swelling………………………	No	Yes	
Weakness of muscles or joints…………………	No	Yes	
Muscle pain or cramps…………………………	No	Yes	
Back pain……………………………………….	No	Yes	
Cold extremities………………………………..	No	Yes	
Difficulty in walking……………………………	No	Yes	
SKIN			
Rash or itching………………………………….	No	Yes	
Change in skin color……………………………	No	Yes	
Change in hair or nails………………………….	No	Yes	
Varicose veins…………………………………..	No	Yes	
Breast pain………………………………………	No	Yes	
Breast lump……………………………………..	No	Yes	
Breast discharge…………………………………	No	Yes	
NEUROLOGICAL			
Frequent or recurring headaches………………..	No	Yes	
Light headed or dizzy…………………………...	No	Yes	
Convulsions or seizures…………………………	No	Yes	
Numbness or tingling sensations………………..	No	Yes	
Tremors………………………………………….	No	Yes	
Paralysis………………………………………..	No	Yes	
Stroke……………………………………………	No	Yes	
PSYCHIATRIC			
Memory loss or confusion………………………	No	Yes	
Nervousness…………………………………….	No	Yes	
Depression……………………………………….	No	Yes	
Sleep problems………………………………….	No	Yes	
ENDOCRINE			
Glandular or hormone problem…………………	No	Yes	
Thyroid disease…………………………………	No	Yes	
Excessive thirst or urination……………………	No	Yes	
Heat or cold intolerance………………………..	No	Yes	
Dry skin………………………………………....	No	Yes	
Change in hat or glove size…………………….	No	Yes	
HEMATOLOGIC/LYMPHATIC			
Slow to heal after cuts………………………….	No	Yes	
Easily bruise or bleed…………………………..	No	Yes	
Anemia………………………………………….	No	Yes	
Phlebitis…………………………………………	No	Yes	
Past transfusion…………………………………	No	Yes	
Enlarged glands…………………………………	No	Yes	

☐ History was filled out by other than patient.

Name and Relationship:

____

____

Patient Signature: ____

☐ I have reviewed and confirmed this information with the patient.

Provider Signature: ____