

GRAYSON PRIMARY CARE

Michele Aguayo, M.D. FAAFP • Sangita A. Sharma, MD

2594 Loganville Hwy, Suite 101 • Grayson, GA 30017

(678) 225-4999 • Fax (678) 225-5546

NAME _____

DOB _____

Please list the following:

MEDICAL PROBLEMS/DIAGNOSIS (with approximate dates)

NONE

ALLERGIES (include reaction)

NONE

SURGERIES (with approximate dates)

NONE

FAMILY HISTORY

Please indicate family members who have one of the following illnesses:

Diabetes	Stroke
Asthma	Cancer
Seizures	Sickle Cell
Tuberculosis	Alcohol/Substance abuse
Heart Problems	Psychiatric disorder
Hypertension	Other

My sexual orientation is (circle):

hetero-sexual

homo-sexual

bi-sexual

Anything else that you think your physician should know about you?

Patient Signature _____ Date _____

Physician Signature _____ Date _____

NEW PATIENT HISTORY



Grayson Primary Care

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Grayson Primary Care may include consent at satellite offices under common ownership.

I, the undersigned, authorize Grayson Primary Care to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Grayson Primary Care.

I acknowledge that I have been given the Grayson Primary Care Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I have had the opportunity to have all of my questions addressed to my satisfaction. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date



GRAYSON PRIMARY CARE

LIABILITY WAIVER

In order to accommodate the needs and requests of our patients, Grayson Primary Care has enrolled in numerous managed care insurance programs.

Each program has different stipulations regarding how often services may be rendered, and even more importantly, where and when those services may be performed. Within the same insurance company the plans differ, depending upon what type of contract you or your employer have 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 the time of each service what those guidelines are. In addition, if any type of authorization is needed for your insurance plan, it is the patient's responsibility to bring the necessary paperwork at the time services are rendered, to insure proper filing to your insurance provider.

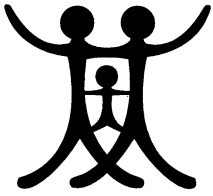
With your cooperation and help, we can focus on your health care needs while you receive all the benefits available under your insurance plan.

I have read and understand the above stated policy and accept financial liability for services above, beyond, and not covered by my insurance carrier's limitations.

Patient/Guardian Full Name-Print

Patient/Guardian Signature

Date of Service



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Date _____

Name _____ Sex _____

Birthdate _____ SSN# _____

Person Responsible for Payment _____

Address _____
Street # and Name City State Zip Code

Home Phone _____ Work Phone _____

Marital Status _____ Spouse's Name _____

Insurance Information

Primary Insurance	Policyholder Name
Policyholder Sex	Policyholder Birthdate
Policyholder SSN#	Policyholder Relation to Patient
ID#	Group#
Secondary Insurance	Policyholder Name
Policyholder Sex	Policyholder Birthdate
Policyholder SSN#	Policyholder Relation to Patient
ID#	Group#

Employer _____ Work Phone _____

Person to Contact in case of emergency _____

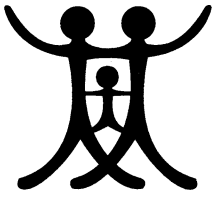
Relationship _____ Phone _____

Names of other members of your family seen in this office _____

Patient, please sign for permission to treat

If patient is a minor, parents sign here for permission to treat in your absence

****Please turn over to complete on back side**



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PLEASE CIRCLE THE CORRECT RESPONSE TO THE FOLLOWING QUESTIONS:

May we release test results to your:

Spouse? YES NO Name: _____

Parent? YES NO Name: _____

Child? YES NO Name: _____

Other? YES NO Name: _____

May we leave a message concerning results on your answering machine? YES NO

May we call your place of employment? YES NO

*****YOU HAVE COMPLETED THE PATIENT REGISTRATION PROCESS*****

PLEASE RETURN THIS FORM TO THE RECEPTIONIST WITH YOUR INSURANCE CARD

The following fields are utilized upon verification of information contained on this form at future appointments:

Date: _____	Signature: _____	Date: _____	Signature: _____
Date: _____	Signature: _____	Date: _____	Signature: _____
Date: _____	Signature: _____	Date: _____	Signature: _____
Date: _____	Signature: _____	Date: _____	Signature: _____



GRAYSON PRIMARY CARE

Board Certified Family Practice

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Reviewed By

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

Date

Relationship to Patient

Date