Kennestone Internal Medicine Associates

Consent for Purposes of Treatment, Payment and Healthcare Operations

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this form can and will be used to:

- Conduct, Plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain Payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and Physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand I have a right to review Kennestone Internal Medicine Associates (KIMA) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of healthcare operations of KIMA. This Notice of Privacy Practices also describes my rights and KIMA's duties with respect to my protected health information.

Name of Patient or Representative: _____

Signature of Patient or Representative: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason: _____

KENNESTONE INTERNAL MEDICINE ASSOCIATES

PATIENT DEMOGRAPHICS

Today's Date:_____

Name:_____ Age:_____ DOB:_____

SS#_____ Are you? __ Single __ Widowed __ Divorced __Married

Street Address:_____

City:_____ Zip Code:_____

Home Phone: _____Ok to leave message?_____

Cell Phone: _____Ok to leave message?_____

Work Phone:_____ Ok to leave message?_____

Email at home:_____ Email at work:_____

Is patient a minor? ___Yes ___No If yes, responsible party name:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relation:_____

Emergency Phone Numbers:_____

INSURANCE INFORMATION

If you have insurance coverage but cannot show a valid insurance card at the time of visit, the patient will be responsible for the bill until insurance information is received.

Name of Insured:_____ Relation:_____

Primary Insurance:_____ Secondary Insurance:_____

My signature below authorizes the release of all pertinent information requested by my insurer, SSI, HCFA, and/or any parties involved in the payment and/or settlement of my insurance claims. A copy of this authorization may be used in place of the original and should be considered effective until revoked by me in writing. Payment should be directed to Kennestone Internal Medicine Associates, P.C, as medical assignments of benefits apply.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Kennestone Internal Medicine Associates
Robert J. Ollins, M.D.
David M. Lahasky, M.D.
790 Church St. NW, Suite 325
Marietta, GA 30060

Home Phone _____

Work Phone _____

PATIENT NAME _____

MR # _____

DOB _____

_____

MEDICAL HISTORY

Today's Date _____

The purpose of the following questions is to obtain a complete medical history which will be entered into your permanent medical record. This health survey will also help your primary care provider to become familiar with you and with any medical difficulties you may have. Your medical history is of course confidential, as are the other parts of your medical record. Please answer the questions to the best of your ability.

A. Social History

Please fill in the blanks or circle your answer

1. Date of Birth _____ / _____ / _____

2. Marital Status: Single Married

Separated Divorced Widowed

3. If you are married, is your spouse healthy? Yes No

Spouse's Name _____

4. Do you have children? Yes No
Child's Name(s) _____
_____
_____
_____

5. Are you employed? Yes No
Employer's Name _____
_____

6. If employed, please describe your daily activities at work briefly
_____
_____
_____
_____

B. FAMILY HISTORY		IF LIVING Age	IF LIVING Health	IF DECEASED Age at Death	IF DECEASED Cause	HAS ANY BLOOD RELATIVE EVER HAD – Please Check:		Who?
Grandfather (father's side)						Diabetes		
Grandmother (father's side)						Tuberculosis		
Grandfather (mother's side)						Cancer		
Grandmother (mother's side)						High blood pressure		
Father						Epilepsy		
Mother						Hemophilia		
Brother	1.					Anemia		
or Sister	2.					Heart attack		
	3.					Heart Disease		
	4.					Stroke		
	5.					Kidney Disease		
	6.					Lung Disease		

C. Allergies

1. List any medications to which you are allergic:
_____
_____
_____
_____

2. List anything else you are allergic to:
_____
_____
_____
_____

D. General Medical History (2)

1. SURGERY: Have you had an operation on any of the following:

( ) Appendix
( ) Gall Bladder
( ) Kidney
( ) Tonsils
( ) Tumor of any Kind
( ) Varicose Veins
( ) Thyroid
( ) Breast
( ) Hernia
( ) Hemorrhoids
( ) Chest
( ) Other _____

2. ILLNESSES: Have you ever had any of the following:

( ) Anemia
( ) Bleeding Disorder
( ) Jaundice
( ) Diabetes
( ) Cancer
( ) Migraine
( ) Blood Clots or Phlebitis
( ) Heart Disease
( ) Heart Murmur
( ) High Blood Pressure
( ) Blood Transfusions
( ) Hernia
( ) Hemorrhoids
( ) Colitis
( ) Arthritis
( ) Bone Disease
( ) Back Trouble
( ) Asthma or Hayfever
( ) Convulsion
( ) Kidney Stone
( ) Nervous Breakdown
( ) Varicose Veins
( ) Ulcer
( ) Gall Bladder Disease
( ) Tuberculosis
( ) Hepatitis
( ) Pneumonia
( ) Skin Disease
( ) Allergies or Drug Reactions
( ) Other _____

3. MEDICATIONS: Check any of the following medications you are presently taking or have taken in the past year.

( ) Cortisone or Steroids
( ) Blood Pressure Pills
( ) Thyroid
( ) Heart Medicine
( ) Antibiotics
( ) Pain Medicine
( ) Diuretic (Water Pills)
( ) Hormones
( ) Sleeping Pills
( ) Asthma Medicine
( ) Arthritis Medicine
( ) Tranquilizer or Nerve Pills
( ) Diet Pills
( ) Other _____

4. HOSPITALIZATIONS: If you have been hospitalized for any non-surgical illness, please list below (excluding childbirth).

Year	Diagnosis	Hospital	Year	Diagnosis	Hospital

E. Risk Factors

1. Do you now or have you ever smoked cigarettes:

Yes No

2. If so, how many packs per day? _____

3. How many years have you smoked?

_____

4. Do you drink alcohol? Yes No

5. If so, please estimate the amount you drink in one week (include beer, wine, hard liquor):

_____

_____

_____

6. Please estimate the amount of coffee, tea, and caffeinated soft drinks you consume each day.

_____

7. Do you have any type of drug habit?

Yes No

8. Have you ever had a high triglyceride or cholesterol level? _____

_____

9. Do you exercise regularly? Yes No

10. Are you overweight? Yes No

PATIENT NAME _____

MR # _____

Listed below are specific symptoms or conditions you may have had trouble with in the past 6 months, or you may be having trouble with now. They are grouped into body systems such as skin, eye, abdominal organs, etc. Please read each system in its entirety before answering. If you've had no problems with any of the symptoms listed under a given heading, circle no next to the system title. If you are having problems, then circle the yes next to the specific symptom.

F. Systems Review

			FOR PHYSICIAN USE ONLY
1. General Health		No	
fever	yes		
night sweats	yes		
hot flashes	yes		
significant weight gain	yes		
significant weight loss	yes		
loss of appetite	yes		
2. Endocrine Glands		No	
Goiter (enlarged thyroid)	yes		
overactive thyroid	yes		
underactive thyroid	yes		
excessive thirst	yes		
excessive hunger	yes		
3. Skin		No	
rash	yes		
sores	yes		
boils	yes		
eczema	yes		
moles that have changed color or size	yes		
4. Lymph Glands		No	
swelling in the neck	yes		
swelling in the armpit	yes		
swelling in the groin	yes		
5. Eyes		No	
wear glasses or contacts	yes		
eye pain	yes		
Glaucoma	yes		
sudden changes in vision	yes		
double vision	yes		
blurred vision	yes		
blind spots	yes		
6. Ears		No	
difficulty hearing	yes		
drainage from ears	yes		
frequent ear infections	yes		
pain in ears	yes		
7. Nose and Sinuses		No	
frequent nosebleeds	yes		
hay fever	yes		
sinus congestion	yes		

F. Systems Review (Continued)

8. Mouth and Throat		No
sores in mouth	yes	
problems with tonsils	yes	
hoarseness	yes	
9. Lungs		No
cough	yes	
coughing up blood	yes	
shortness of breath	yes	
get winded easily	yes	
emphysema	yes	
chronic bronchitis	yes	
wheezing	yes	
positive tuberculin skin test	yes	
previous chest x-ray	yes	
10. Heart and Blood Vessels		No
chest pain	yes	
chest discomfort	yes	
wake up short of breath	yes	
sleep on two or more pillows	yes	
rapid heart beat	yes	
irregular heart beat	yes	
heart murmur	yes	
rheumatic fever	yes	
palpitation (heart thumps)	yes	
swelling in ankles	yes	
vein problems in leg	yes	
cramps in legs when walking	yes	
11. Abdominal Organs		No
abdominal pain	yes	
bloating after meals	yes	
heartburn / indigestion	yes	
ulcers	yes	
vomiting blood	yes	
liver disease	yes	
jaundice	yes	
hepatitis	yes	
gallstones	yes	
frequent use of antacids	yes	
heavy drinking	yes	
difficulty swallowing	yes	
diarrhea	yes	
constipation	yes	
recent change in bowel habits	yes	
blood or mucus in stools	yes	
black tarry stools	yes	
hemorrhoids	yes	
rectal pain	yes	

FOR PHYSICIAN USE ONLY

PATIENT NAME _____

MR # _____

F. Systems Review (Continued)

12. Kidneys or Bladder		No
difficult or painful urination	yes	
blood in urine	yes	
can't hold urine	yes	
very frequent urination	yes	
get up more than once at night to urinate	yes	
frequent infections	yes	
kidney disease	yes	
kidney stones	yes	
protein in urine	yes	
sugar in urine	yes	

13a. Genitals (Women only) — No

Age when menstrual periods began _____

Date last period began _____

Please indicate number of:

- Pregnancies _____
- Normal deliveries _____
- Premature deliveries _____
- Miscarriages _____
- Abortions _____
- Living children _____

Date of last pap smear: _____

_____

Birth control method: _____

_____

Do you know how to examine your breasts	yes	no
abnormal pap smear	yes	
unusual vaginal discharge	yes	
irregular periods	yes	
abnormal bleeding	yes	
pain on intercourse	yes	
pelvic pain	yes	
problems with sex	yes	
breast lumps	yes	
nipple discharge	yes	
venereal disease	yes	

13b. Genitals (Men only)		No
sores on penis	yes	
discharge from penis	yes	
prostate gland trouble	yes	
difficulty voiding	yes	
impotence	yes	
venereal disease	yes	

FOR PHYSICIAN USE ONLY

F. Systems Review (Continued)

14. Muscles, Bones and Joints		No
deformities	yes	
muscle weakness	yes	
pain in joints	yes	
chronic pain in back	yes	
swelling in joints	yes	
gout	yes	
15. Nervous System		No
frequent or severe headaches		
head injury	yes	
seizures / fits / convulsions, epilepsy	yes	
numbness or tingling	yes	
weakness	yes	
feel sad or depressed	yes	
difficulty sleeping	yes	
suicidal thoughts	yes	
severe anxiety	yes	
desire psychiatric help	yes	

16. Immunizations

Please give year of last injection:

Tetanus _____

Tuberculosis skin test _____

FOR PHYSICIAN USE ONLY