

PATIENT REGISTRATION FORM

Date:

LAST NAME			FIRST NAME			MIDDLE NAME		
BIRTH DATE (mm/dd/yyyy)			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	I IDENTIFY MYSELF AS: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		PHARMACY		
MAILING ADDRESS			CITY			STATE		ZIP
HOME PHONE		WORK PHONE		MOBILE PHONE		E-MAIL ADDRESS		
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		INTERPRETER NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No	PREFERRED LANGUAGE		RACE <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
COMMUNICATION PREFERENCE <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Patient Portal						PRIMARY CARE PHYSICIAN		

EMPLOYER INFORMATION

PATIENT'S EMPLOYER			OCCUPATION			WORK PHONE		
BUSINESS ADDRESS			CITY			STATE		ZIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP		HOME PHONE		WORK PHONE		MOBILE PHONE	
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GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GUARANTOR'S NAME				RELATIONSHIP				
ADDRESS (IF DIFFERENT FROM ABOVE)						DATE OF BIRTH		SEX
EMPLOYER			HOME PHONE		WORK PHONE		MOBILE PHONE	
NAME OF ADULT PRESENTING MINOR FOR TREATMENT					RELATIONSHIP			

INSURANCE INFORMATION

INSURANCE COMPANY (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SUBSCRIBER ID		GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER	
SECONDARY INSURANCE (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SUBSCRIBER ID		GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER	

Who may we thank for referring you to our office?

How did you hear about our office?

We look forward to being a part of your healing and journey to better health!



INNOVATIONMD

Patient Name: _____ DOB: _____

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, modalities, x-rays, drug or laboratory test, medication or exam as may be deemed necessary by the physician.
- I understand I have the right to see a physician if I so choose and have the right to see a physician prior to any prescription drug or modality order being carried out by any health care professional.

• Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information: (Name and relation-Example: Jane Doe, Wife; Jan Doe, Daughter)

- 1) _____ Relationship: _____
- 2) _____ Relationship: _____
- 3) _____ Relationship: _____

• If you do not authorize information to be released to anyone please check this statement.

- I do not authorize any information to be released to anyone other than myself.

I hereby authorize messages to be left on a voicemail system or answering machine.

Please indicate the number(s) Innovation MD staff can utilize to leave a message for you:

- 1) _____ 2) _____

Patient Signature: _____ **Date:** _____



Patient Financial Policy

Thank you for choosing Innovation MD to achieve your health goals. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our office manager.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is responsible for the payment for his/her treatment and care before services are rendered.
- Our services are NOT covered by insurances.
- Payment of procedures or treatments is due at the time of service.
- For your convenience, we accept **CareCredit, Visa, MasterCard, American Express, Discover, cash and checks** at our office.
- If an approved payment plan is not paid after 90 days of rendered service, the balance will accrue an additional 35% after being submitted to collections.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Innovation MD Management. These charges may include (but not limited to): charges for returned checks charge for missed appointments without 24-hour advance notice charge for the copying and distribution of patient medical records any costs associated with collection of patient balances

Patient Authorizations

By my signature below, I hereby authorize assignment of financial benefits directly to Innovation MD and any associated healthcare entities for services rendered. By my signature below, I authorize communication by Innovation MD personnel via mail, answering machine message, and/or email according to the information I have provided in my patient registration information. I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Patient Name/ Date of Birth: _____

Patient Signature: _____

Date: _____



PHYSICIAN DISCLOSURE & PATIENT ACKNOWLEDGMENT OF HEALTH SERVICES

Notice to Patients:

Under Georgia Law, a health care provider may not refer a patient for the provision of designated health services to an entity in which the health care provider has an investment interest according to the provisions set forth in O.C.G.A 43-1B-5. The law prohibits me, with certain exceptions, from referring you for designated health services to a facility in which I or any of my immediate family members have a financial interest.

Designated health services as defined by Georgia law include clinical laboratory services, physical therapy services, rehabilitation services, diagnostic imaging services, pharmaceutical services, durable medical equipment, home infusion therapy services (including related pharmaceuticals and equipment), home health care services, and outpatient surgical services.

If exceptions in the law apply, or if I am referring you for services other than those listed above, I can make the referral under the condition that I disclose my financial interest and tell you about alternative providers where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

I, P. Tennent Slack, MD, or my immediate family members have a financial relationship with the following providers: **Northeast Georgia Physicians' Group**

For more information about alternative providers, please ask me or my staff. We will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Patient Name/ Date of Birth: _____

Patient Signature: _____

Date: _____



INNOVATIONMD
New Patient Paperwork

DATE: _____ NAME: _____ DOB: ___/___/___ AGE: _____

What problem are we seeing you for? _____

How long have you had this problem? _____

Have you had any imaging for your complaint (MRI, X-ray, CT, EMG)? _____

PAST MEDICAL HISTORY (Circle any of the following conditions you have been diagnosed with):

Headaches	High Blood Pressure	Congestive Heart Failure	Anemia
Implanted Devices	Low Blood Pressure	Stomach Ulcers	Epilepsy
Stroke	Syncope	Diabetes	Arthritis
TIA	High Cholesterol	Liver Disease	Fibromyalgia
Carotid Artery Disease	Thyroid Disease	Hepatitis	Psychiatric Disorder
Coronary Artery Disease	Asthma	Kidney Stones	Anxiety
Heart Attack	Emphysema/COPD	Kidney Disease	Depression
Abnormal Heart Rhythm	Cancer	Osteoporosis	Claustrophobia

Other: _____

PAST SURGICAL HISTORY (Circle any of the following surgeries you have undergone):

Back Surgery	Carotid Surgery	Carpal Tunnel Repair	Gall Bladder
Neck Surgery	Cardiac Stent	Hysterectomy	Gastric Bypass
Joint Replacement	Pacemaker	Appendectomy	Spinal Cord Stimulator

Other: _____

SOCIAL HISTORY:

Alcohol Use: Yes No Frequency: _____

Tobacco Products: Current Former Never E-cigarettes

Currently working? Yes No Occupation: _____

Disability? Yes No Pending Seeking

Caffeine Beverages per day? _____

Under Stress? Yes No

Marital Status: _____

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list relationship to affected individual(s):

Heart Disease _____

Hypertension _____

Stroke _____

Back Surgery _____

Headaches _____

Cancer _____

Kidney Disease _____

Neuropathy _____

Seizure Disorder _____

Diabetes _____

Brain Aneurysm _____

Osteoporosis _____

Psychiatric History _____

Drug Abuse _____

Parkinson's Disease _____

Arthritis _____

Trembling _____

REVIEW OF SYSTEMS (Circle any of the following symptoms you have experienced in the past 6 months):

Constitutional

Activity change
Appetite change
Fatigue
Fever
Unexpected weight change

HENT

Congestion
Ear pain
Hearing loss
Nosebleeds
Runny nose
Sinus pain
Sore throat
Ringing in the ears
Difficulty swallowing
Voice change

Eyes

Eye pain
Eye redness
Sensitivity to light
Visual disturbance

Respiratory

Chest tightness
Cough
Shortness of breath

Cardiovascular

Chest pain
Leg swelling
Palpitations

Gastrointestinal

Abdominal distention
Abdominal pain
Constipation
Diarrhea
Nausea
Vomiting

Endocrine

Cold intolerance
Heat Intolerance

Genitourinary

Large volume of urine
Painful urination
Urinary Frequency

Musculoskeletal

Joint pain
Back pain
Difficulty Walking
Joint swelling
Muscle pain
Neck pain

Skin

Color change
Rash

Allergies/Immune System

Food allergies
Immuno-compromised

Neurological

Dizziness
Headaches
Light-headedness
Numbness
Seizures
Speech difficulty
Syncope
Tremors
Weakness

Hematologic

Bruises/bleeds easily

Psychiatric

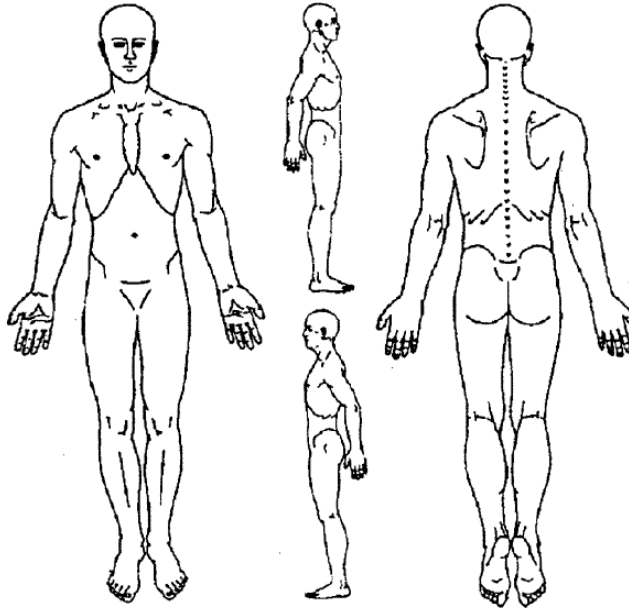
Agitation
Behavior problem
Confusion
Decreased concentration
Persistent bad mood
Hallucinations
Nervous/anxious
Sleep disturbance

Pain Survey

Name: _____ **Date:** _____

Location: In what part of your body is your pain the worst? _____

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

- Aching Burning Cold Electric Shock Dull Hot/Flushed Numb Tingling Stabbing
 Sharp Pins & Needles Throbbing Other (describe): _____

Rate the severity of your pain at its worst on this scale (1 = mild, 10 = worst pain of your life):

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Radiation/Referral Pattern: Does your pain travel to other locations? Yes No If yes, where? _____

Describe the frequency of your pain. Daily Weekly Monthly Constant Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst? _____

Aggravating Factors: What worsens the pain? _____

Alleviating Factors: What makes the pain better? _____

Activity: Are you exercising, walking, stretching, etc? _____

How Many Hours of Sleep do you average per night? _____ **Would you consider this quality sleep?** Yes No

How would you describe your mood? Irritable Sad Happy most of the time Other: _____

Are you currently working? (Circle one) Full-Time Part-Time Not Currently Working

