



Welcome and thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to take this opportunity to familiarize you with our office policies:

**Please bring the following items to your first visit:**

- Insurance Card(s), Picture ID and Co-Pay
- The name(s), address, phone/fax numbers to your previous doctors to obtain your medical records.
- **All medications you are currently taking in the bottles.**
- All NEW PATIENT paperwork, health history and required signatures.

**Reminders:**

- *It is your responsibility to know the benefits that you receive from your insurance company.* This includes wellness/physical coverage, deductible amounts, and co-payment requirements.
- For your convenience, we provide onsite lab services from Quest Diagnostics. If your insurance requires you to use a specific reference laboratory, it is your responsibility to tell us before labs are drawn so that you may be given an order sheet to go to an outside lab that insurance covers.
- In compliance with HIPAA laws, no information will be given to anyone, including family, without prior written consent.
- New Patients will only be allowed to reschedule or cancel their initial appointment twice. Failure to contact the office to cancel or reschedule new patient appointment will result in dismissal from the practice and unable to return.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for the Providers will be directed to the nurses.
- We provide same day and walk in appointments for our established patients.

Our goal is to provide you with the most efficient and up to date health care available. We are always open to suggestions. We look forward to seeing you!

Sincerely,

Dr. Mary Bell Vaughn and Vineville Internal Medicine Staff

[www.vinevilleinternalmedicine.com](http://www.vinevilleinternalmedicine.com)



Be sure to like us on Facebook



And Instagram @ vinevilleinternalmedicine

Your Appointment is scheduled for ____/____/____ at ____:____			
3448 Vineville Avenue, MACON			
Bldg A - Blue Balloons	Bldg B - Green Balloons	Bldg C - Purple Balloons	Bldg D - Yellow Balloons
( ) Erin Caves, NP	( ) Mary Bell Vaughn, MD	( ) Ashley Dykes, NP	( ) Jenna Franz, NP
( ) Jarrett Mitchell, NP	( ) Lauren Lambeth, NP	( ) Krista Keen, NP	( ) Daryl Remick, MD
( ) Daryl Remick, MD	( ) Shandora Hayman- Jones, NP	( ) Sarah Purser, NP	
	( ) Shannon Ethridge, NP		
	( ) Tammy Hughes, NP		
1024 Keith Drive, PERRY			
( ) Kim Johnson, NP	( ) Gina Wiley, NP	( ) Tammy Hughes, NP	



## **3448 Vineville Ave, Macon GA**

### **Coming from I-75 South:**

Take the Hardeman Ave./Forsyth exit. Go straight through the first red light. Turn left at second red light onto Hardeman Ave. Go 2.3 miles. Turn left onto Prentice Place and turn right into the back-parking lot.

### **Coming from I-75 North:**

Take the Hardeman Ave. exit. Turn right at the first red light. Go 2.3 miles. Turn left onto Prentice Place and turn right into the back-parking lot.

### **Coming from Forest Hill Rd:**

Turn left onto Vineville Ave, at the Forest Hill/Park St. Intersection. Go straight past Walgreen's and turn on the 6<sup>th</sup> street on the right called Prentice Place. Turn right into the back-parking lot.

### **Coming from Zebulon Rd:**

Take Zebulon Rd. to Forsyth Rd. Turn right. Go approx. 2.4 miles to the Forest Hill/Park St. intersection. Go straight past Walgreen's and turn on the 6<sup>th</sup> street on the right called Prentice Place. Turn right into the back-parking lot.

## **1024 Keith Drive, Perry GA**

### **Coming from I-75 South:**

Take Exit 138 Thompson Rd/Perry Pkwy. Turn left onto Perry Pkwy and continue through the first red light. At the second light, turn right onto Houston. In 0.5 miles, turn left onto Keith Drive. Go straight through the 4-way. In approximately 0.5 miles, turn left into parking lot.

### **Coming from I-75 North:**

Take Exit 135 Perry/Larry Walker Pkwy. turn right onto Perry Pkwy. Then, turn left at the first light onto General Courtney Hodges Blvd. In 1.1 miles, turn right onto Main Street. Continue for 1.9 miles and then left turn onto Keith Drive. Go another .3 miles, turn right into parking lot.

### **Coming from Hawkinsville (Taylor Regional Hospital):**

Take a right on US-341 N/Golden Isles Pkwy. In 11 miles, turn right onto US-341 N/Main Street. After 7.2 miles, turn right onto Keith Drive. After 0.3 miles, turn right into parking lot.



Thank you for choosing Vineville Internal Medicine (VIM) for your healthcare needs. We are committed to providing quality and affordable health care to you and your family. Because some of our patients have questions regarding general practice guidelines and patient financial responsibility for services rendered, we have developed these policies for your information and future reference. Please read them, ask any questions you may have and sign in the space provided. You may keep all pages other than the signature page (the last page).

## **General Practice Policies**

**Telephone Calls: If you have a medical emergency, please call 911.**

Due to heavy call volumes, some calls will be transferred to a voice mail box. The voice mails are monitored continuously throughout the day. All calls received before 4pm will be returned within the same business day.

The following options are available:

- |  |  |
|--|--|
| #1- Refills  | #4- Nurse Calls  |
| #2- Billing Questions related to billing or insurance claims | #5- Provider Calls (Copay/Visit charges applied to Provider calls) |
| #3- Appointments   |  |

**Medication Refills:** All refills and prescription renewals should be initiated through your pharmacy. Please notify your pharmacy when you need a refill, and they will contact our office for approval. If there aren't any authorized refills remaining, you will need to contact our office to make an appointment for evaluation to ensure there are no issues with your medications. To schedule an appointment, you may contact us directly at 478-405-0045, option #3, or use the Patient Portal Healow App to schedule an appointment. We request 72 hours to process all prescription refills.

**Missed Appointments:** To ensure the best outcome for every patient, we feel strongly that every appointment is medically necessary. Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Our system is set to call and/or text reminders of your scheduled appointments. Please ensure that your preferred method of contact and contact information are up to date in our system and respond to these calls accordingly. Although we understand that emergency situations may arise, a quick call to cancel your appointment would be appreciated. Due to high demand and limited availability of same day appointments we have instituted a "missed appointment" fee. You must give at least a 24hr advance notice to cancel or reschedule appointments. Failure to do so will result in a "missed appointment" fee charge of \$25.00-\$50.00 to your account, depending on the service scheduled. These fees are patient responsibility, will be billed directly to you and should be paid before scheduling another appointment.

**Dismissal:** As a last resort, repeated failure to keep your scheduled appointments or failure to comply with practice treatment policies may result in dismissal from the practice. Dismissal may also occur if your account has carried an unpaid balance after the 3<sup>rd</sup> billing statement without making payment arrangements. If for any reason you have been dismissed from VIM, you will be notified by regular and/or certified mail that you have 30 days to seek alternative care. During that 30-day period, your provider will only be able to provide treatment on an emergent basis.

## **Financial Policies**

**Identification and Proof of Insurance:** At each visit you will be asked to provide driver's license/picture ID and current insurance card. Please be sure to bring these to each appointment so we can ensure accurate information in your patient account. We have made prior arrangements with many insurers and health plans to accept assignment of benefits and participate in most insurance plans, including Medicare and Medicare Advantage plans. We are happy to file insurance to your primary and secondary insurance as a courtesy. Your insurance will be verified prior to each visit or procedure. If we are unable to verify your coverage prior to your visit, you will be considered a self-pay patient and payment in full will be expected until your coverage can be re-established.

### **Minor Patients:**

Patients under the age of 18 will not be seen without a parent/guardian present or without signed consent form. For all services Rendered to minor patients, we will look to the adult accompanying the patient for payment.

**Self-Pay Patients:**

For all services rendered to patients without insurance or proper proof of insurance, a self-pay discount will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Should any test performed result with any abnormalities, additional testing may be required and will fall under the patients' responsibility for those charges.

**Insurance Coverage:** If your insurance changes, please notify our office prior to your visit so that the necessary updates can be made to ensure you receive the maximum benefits. We will submit your primary and secondary insurance claims; however, resolving any claims issues that require additional information from you are your responsibility. If additional information is requested, failure to respond to VIM or your insurance company will result in the unpaid balance being moved to your financial responsibility. If your insurance company does not respond to our claim with payment or denial within 45 days, unpaid charges may be billed directly to you. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any specific questions you may have regarding your benefits, deductible, and coverage limitations.

**Co-payments, Co-Insurance and Deductibles:** Payment of co-pays, co-insurance and deductibles are part of your contract with your insurance company and are required per our agreement to accept your plan. Please help us in upholding the terms of these contracts by paying your co-payment at each visit. We will attempt to verify your out-of-pocket expense prior to any procedures being performed but pre-certification does not guarantee payment by your insurance company and therefore could become patient responsibility after the claim has paid. If we cannot determine this amount at the time of your visit, patient responsibility will be assigned after your insurance company has processed the claim and submitted payment to VIM. This balance is due upon receipt of your statement.

**Non-covered services:** Some recommended services may be ordered by your provider but may be deemed as not reasonably necessary by Medicare or your insurance company based on plan limitations and/or your benefit structure. When possible, you will be advised in advance if we believe the service may not be covered, the reason it may not be covered and the anticipated charges for these services. Services that are never covered or services that exceed your limits of coverage will be billed directly to you. For example, Medicare only covers a well-woman exam every two years. If you have scheduled these visits annually, you will be charged for the service that exceeds frequency limitations. For traditional insurance, annual physicals are typically scheduled at least 366 days apart. If you are having cosmetic procedures, payment in full is expected at the time of service and no claim will be filed to your insurance. We will try our best to notify you of these circumstances; however, understanding the benefits of your insurance is ultimately your responsibility.

**Preventive Services/Sick Visit on the Same Day:** Preventive services are traditionally scheduled at regular intervals to collect or update basic patient information related to history, physical status, and to make plans for additional services that may be required to ensure patient wellness. In some cases, a patient may request or require additional services outside of what is traditionally provided in a preventive/wellness visit. If your provider feels that the sick portion of the visit requires significant additional work and/or follow-up, you may be assessed an office visit charge or co-pay for the separate sick visit.

**Multiple Statements:** VIM bills for services provided by the physicians and providers in the practice. Ancillary services such as laboratory, pathology, or radiology services, etc., may be billed by an outside medical vendor. Therefore, you may receive separate statements from those offices. Please pay each statement separately.

**Non-payment:** If any balance is over 90 days past due, your final statement will notify you that you have **20 days** to pay your account in full to avoid being turned over to an outside collection agency. Partial payments will not be accepted unless a payment agreement has been established and followed as scheduled. If at any point a payment is missed, the collection process will pick up where it left off and the account will be referred immediately to an outside agency. In the event your account balance is referred to a collection agency, your account will be made inactive and you will be dismissed from Vineville Internal Medicine. Additionally, because of the high expense related to using an outside collection agency, additional fees will be added to your account to help cover that additional expense.

**Credit Balances:** In the event that a credit balance is created for any VIM service date, we will verify that there are no outstanding balances on any other date of service and no upcoming appointments before initiating a refund. Because of the administrative expense of processing a refund, any credit balance of \$20.00 or less will remain on the account for use at a future visit unless the refund is specifically requested by the patient or guarantor.

**PLEASE RETURN THIS SHEET TO THE FRONT DESK**

(Form Version 4/18/23)

Our practice is committed to providing the best treatment to our patients. In return, your adherence to these office and financial policies is requested and expected. Please let us know if you have any questions or concerns.

I have read and understand the Vineville Internal Medicine policies dated and agree to comply with these terms as outlined above. (Initial Here \_\_\_\_\_)

**Patient Information:**

Name (Last, First): \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Sex (Select One): Male / Female

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security# \_\_\_\_\_ Employer: \_\_\_\_\_

**Please tell us how to contact you:**

I authorize Vineville Internal Medicine to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Home telephone # \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Home Answering Machine Yes \_\_\_ No \_\_\_

Cell Phone # \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Cell Phone Text/Voice Mail Yes \_\_\_ No \_\_\_

Work telephone # \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Work Voice Mail Yes \_\_\_ No \_\_\_

**VIM Patient Portal:**

We comply with the Hitech Act of 2009 by communicating with our patients via patient portal.

Are you signed up for the portal? Yes \_\_\_ No \_\_\_ I don't want to sign up \_\_\_

I acknowledge that I will receive electronic billing statements upon enrolling in the patient portal. (Initial here \_\_\_\_\_)

**Health Information Disclosure (HID):**

List anyone that may call on your behalf to discuss your health information:

Spouse/Partner Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Other Name/Relationship: \_\_\_\_\_ / \_\_\_\_\_ Phone # \_\_\_\_\_

Other Name/Relationship: \_\_\_\_\_ / \_\_\_\_\_ Phone # \_\_\_\_\_

**( ) Check if you DO NOT want your emergency contact or anyone else to have HID access**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this signature sheet to the front desk with your other patient information (Central Georgia Health Exchange Consent Form and Medical Records Release form). You may keep all the other printed information for your use.

We look forward to creating a long-lasting medical partnership.

Good Health!

*Vineville Internal Medicine*



Vineville  
Internal  
Medicine

Mary Bell H. Vaughn, MD

## Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Records being requested from:

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

The information you may release subject to this signed release form is as follows:

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Complete Records ( <b>last 2 years</b> ) | <input type="checkbox"/> Lab Reports      | <input type="checkbox"/> Pathology Reports    |
| <input type="checkbox"/> Progress Notes                                      | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> H&P   | <input type="checkbox"/> Rx Records       | <input type="checkbox"/> Hospital Reports     |
| <input type="checkbox"/> Other (Please specify below)                        |   |   |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(ONLY if this applies to you)**

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies,

Please initial and date this form. Initial: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Release my protected health information to the following physician/facility:

Dr. Mary Bell Vaughn  
Vineville Internal Medicine  
3448 Vineville Ave  
Macon, Ga 31204

**Phone: 478-405-0045**  
**Fax: 478-405-0054**

Patient Name (Please Print) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



# CENTRAL GEORGIA HEALTH EXCHANGE

*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 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 wish to participate in the Central Georgia Health Exchange electronic medical record at this time

\_\_\_\_\_ / / \_\_\_\_\_ / /  
**Printed Name of Patient/Representative**      **DOB**      **Signature**      **Date**

### **AUTHORITY OF REPRESENTATIVE:** POA

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 you're 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 v II* 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 re-disclosure. 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 healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 111 Perimeter Parkway Macon, GA 31210. 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 my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) through the *Central Georgia Health Exchange*.

**Patient Name:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Age** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Last Physical** \_\_\_\_\_

**Reason for your visit today** \_\_\_\_\_

Conditions & Symptoms (Check the conditions or symptoms you currently have or have had in the past year)

<u>General</u>	<u>Gastrointestinal</u>	<u>Ophthalmology</u>	<u>Skin</u>
<u>Specialists:</u> <input type="checkbox"/> Appendicitis <input type="checkbox"/> Chills <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Hernia <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Organ Transplant <hr/> <input type="checkbox"/> Ulcers <input type="checkbox"/> Sweats <input type="checkbox"/> Measles <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Mumps <input type="checkbox"/> Polio <b><u>Muscle/Joint/Bone</u></b> <u>Specialist:</u> Pain, weakness or numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Arthritis <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <b><u>Infectious Diseases</u></b> <u>Specialist:</u> <input type="checkbox"/> AIDS <input type="checkbox"/> HIV Positive <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Venereal Disease <b><u>Pulmonary</u></b> <u>Specialist:</u> <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <b><u>Endocrinology</u></b> <u>Specialists:</u> <input type="checkbox"/> <u>Diabetes</u> <input type="checkbox"/> <u>Goiter</u> <input type="checkbox"/> <u>Thyroid Problems</u>	<u>Specialists:</u> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <b><u>Psychiatric</u></b> <u>Specialists:</u> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Suicide Attempt <b><u>Hematology/Oncology</u></b> <u>Specialists:</u> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Cancer <b><u>Rheumatology</u></b> <u>Specialists:</u> <input type="checkbox"/> Gout <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <b><u>Nephrology</u></b> <u>Specialists:</u> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis Treatment	<u>Specialists:</u> <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Vision-Flashes <input type="checkbox"/> Vision-Halos <b><u>Cardiovascular</u></b> <u>Specialists:</u> <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart Disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <b><u>Neurological</u></b> <u>Specialists:</u> <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Stroke <b><u>Ear, Nose &amp; Throat</u></b> <u>Specialists:</u> <input type="checkbox"/> Allergies <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Tonsillitis	<u>Specialists:</u> <input type="checkbox"/> Acne <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Scars <input type="checkbox"/> Sores that will not heal  <b><u>Genito-Urinary</u></b> <u>Specialists:</u> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <b><u>MEN only</u></b> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <b><u>WOMEN only</u></b> <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Miscarriage <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Other  <b><u>Date of Last:</u></b> Menstrual period _____ Pap smear _____ Mammogram _____ Chest x-ray _____ Echo _____ Colonoscopy _____



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient History (fill in health information about yourself)**

**Current Prescriptions Medications**

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

**Current OTC Medication (this includes vitamins and Herbal treatments)**

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

**Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)**

Name of Drug/Food	Reaction	Type	Status

**Previous Medications Taken (i.e. blood pressure-nontherapeutic/cannot tolerate satins)**

Name of Drug	Dosage in Milligrams	Reason No Longer Taking

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family History (fill in health information about your family)**

Relation	Age	State of health	Age of Death	Cause of Death	Check if, your blood relative had any of the following	
					Disease	Relationship to you
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Stroke	

**Hospitalizations/Operations**

Year	Hospital	Reason for hospitalization and outcome
Have you ever had a blood transfusion? ( ) yes ( ) no		
If yes, please give approximate date _____		
Serious illness/injuries	Date	Outcome

**Pregnancies**

Year of birth	Sex of birth	Complications?

**Health Habits**

(check which you use or do and describe how much you use)

<input type="checkbox"/> Caffeine	
<input type="checkbox"/> Tobacco	
<input type="checkbox"/> Regular Exercise	
<input type="checkbox"/> Soda	
<input type="checkbox"/> Raw Fruit	
<input type="checkbox"/> Vegetables	
<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Fiber	

**Immunizations**

Vaccine	Date Given
Tetanus/Tdap	
Pneumovax (pneumonia)	
Flu	
Gardasil (HPV)	
Varicella (chicken pox)	
Meningococcal	
Hepatitis A	
Hepatitis B	
Zostavax (shingles)	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her practice responsible for any errors or omissions that I may have made in the completion of this form

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Rooming Nurse: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_