PERRY INTERNAL MEDICINE

DAVID J. COX, M.D.
HEATHER H. SORROW, FNP-C
1019 Keith Drive, Suite B
Perry, GA 31069

PATIENT REGISTRATION

NAME:_____
LAST *FIRST* *MIDDLE*

MAILING ADDRESS: _____ **CITY:**_____

COUNTY: _____ **STATE:**_____ **ZIP:** _____

MARRIED STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED (CIRCLE ONE)

SOCIAL SECURITY #:_____ **DATE OF BIRTH:** _____

HOME #_____ **WORK #**_____ **CELL #**_____

E-MAIL ADDRESS:_____

RACE – CIRCLE ONE: White Black Asian Indian **ETHNICITY: Hispanic or Non-Hispanic_**

Messages may be left on my phone: ☐ yes ☐ no **Cell phone ☐** **Work Phone ☐**

EMPLOYMENT: FULL TIME PART-TIME STUDENT UNEMPLOYED RETIRED (CIRCLE ONE)
EMPLOYER: _____

PRIMARY INSURANCE:_____ **POLICY #**_____
GROUP #_____ **NAME OF INSURED:**_____
RELATIONSHIP TO INSURED:_____ **INSURED'S SSN** _____
INSURED'S DATE OF BIRTH:_____

SECONDARY INSURANCE:_____ **POLICY #**_____
GROUP #_____ **NAME OF INSURED:**_____
RELATIONSHIP TO INSURED:_____ **INSURED'S SSN** _____
INSURED'S DATE OF BIRTH:_____

I hearby authorize payment directly to the physician for any professional services endered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance c ompany, unless my insurance plan is one that contracts directly with the physician and they determine tht I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to colletc the amount due on my account by legal litigation, the handling fees, service charges sor court cost will be paid by the undersigned. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

SIGNATURE:_____ DATE:_____

PATIENT NAME: _____DATE:_____

REASON FOR VISIT:_____

The following is very important to your health and treatment. Please accurately complete this form and bring it with you.

Please list the following:

Medication Allergies: _____
Other Allergies: (i.e. latex, iodine, x-ray dye, etc.) _____

Please list the name, dosage and frequency for each **medication and supplements** you are **CURRENTLY** taking. Bring the form to your appointment. If you do not take any medications, please write "NONE" on this form.

	MEDICATION	DOSE/MG	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Name of Pharmacy used:_____

Location:_____

Phone Number:_____

MEDICAL HISTORY

Patient Name:_____Date of Birth:_____

PLEASE CHECK (✍) APPROPRIATE BOX. DO YOU HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

GENERAL HEALTH	**CURRENTLY**	**PAST**		**N/A**	**NOTES:**
Weight Gain	☐	☐		☐	
Weight Loss	☐	☐		☐	
Fever	☐	☐		☐	
Fatigue	☐	☐		☐	
EYES					
Glaucoma	☐	☐		☐	
Double Vision	☐	☐		☐	
Spots in Vision	☐	☐		☐	
Vision Changes	☐	☐		☐	
EARS/MOUTH					
Ear Ache	☐	☐		☐	
Ringing in Ears	☐	☐		☐	
Sinus Problems	☐	☐		☐	
Sore Throat	☐	☐		☐	
Mouth Sores	☐	☐		☐	
Dental Problems	☐	☐		☐	
HEART					
Pacemaker	☐	☐		☐	
Mitral Valve Prolapse	☐	☐		☐	
Tachycardia (excessively fast heart rate)	☐	☐		☐	
Bradycardia (slow heart rate)	☐	☐		☐	
Heart Murmur	☐	☐		☐	
Heart Attack	☐	☐		☐	
Heart Disease	☐	☐		☐	
Chest Pain	☐	☐		☐	
Palpitations	☐	☐		☐	
High Blood Pressure	☐	☐		☐	
Rheumatic Fever	☐	☐		☐	
RESPIRATORY					
Chronic Cough	☐	☐		☐	
Asthma	☐	☐		☐	
Chronic Bronchitis	☐	☐		☐	
Tuberculosis	☐	☐		☐	
Chronic Lung Disease	☐	☐		☐	
Pneumonia	☐	☐		☐	
Wheezing	☐	☐		☐	
Spitting up blood	☐	☐		☐	
Shortness of breath	☐	☐		☐	
Painful/Difficulty Breathing	☐	☐		☐	
GASTROINTESTINAL					
Frequent Diarrhea	☐	☐		☐	
Blood in stool	☐	☐		☐	
Nausea/Vomiting	☐	☐		☐	
Constipation	☐	☐		☐	
Bowel Trouble	☐	☐		☐	
Other:_____	☐	☐		☐	
MEN'S HEALTH	**CURRENT**	**PAST**		**N/A**	**NOTES:**
Enlarged Prostate Gland	☐	☐		☐	
Prostate Cancer	☐	☐		☐	
Prostatitis	☐	☐		☐	

GYNECOLOGY	**CURRENT**	**PAST**		**N/A**	**NOTES:**
Abnormal Pap Smear	☐	☐		☐	
Recurrent Yeast Infection	☐	☐		☐	
Bacterial Vaginitis	☐	☐		☐	
Sexually transmitted Disease (STD'S)	☐	☐		☐	
Endometriosis	☐	☐		☐	
Polycystic Ovarian Syndrome (PCOS)	☐	☐		☐	
Fibroids	☐	☐		☐	
Painful/Abnormal Periods	☐	☐		☐	
GENITOURINARY					
Blood in Urine	☐	☐		☐	
Pain with Urination	☐	☐		☐	
Urge/Frequent Urination	☐	☐		☐	
Painful Intercourse	☐	☐		☐	
Recurrent UTI's	☐	☐		☐	
Kidney Stones	☐	☐		☐	
Kidney Failure	☐	☐		☐	
Kidney Disease	☐	☐		☐	
SKIN/BREAST					
Breast Cancer	☐	☐		☐	
Pain in Breast	☐	☐		☐	
Discharge	☐	☐		☐	
Masses/Lumps	☐	☐		☐	
Rashes/Ulcers	☐	☐		☐	
Dry Skin	☐	☐		☐	
NEUROLOGIC					
Stroke	☐	☐		☐	
Seizures	☐	☐		☐	
Numbness	☐	☐		☐	
Dizziness	☐	☐		☐	
Migraines	☐	☐		☐	
Multiple Sclerosis	☐	☐		☐	
PSYCHIATRIC/PSYCHOLOGICAL					
Depression	☐	☐		☐	
Anxiety	☐	☐		☐	
Obsessive compulsive Disorder (OCD)	☐	☐		☐	
Frequent Crying Spells	☐	☐		☐	
Bi-Polar disorder	☐	☐		☐	
ENDOCRINE					
Thyroid disorder	☐	☐		☐	
Diabetes	☐	☐		☐	
Abnormal Thirst	☐	☐		☐	
Hot flashes	☐	☐		☐	
HEMATOLOCIG/LYMPHATIC					
Frequent Bruises	☐	☐		☐	
Cuts that don't stop bleeding	☐	☐		☐	
Enlarged Lymph Node	☐	☐		☐	
Anemia/Blood Transfusion	☐	☐		☐	
Sickle-Cell Disease	☐	☐		☐	
Hepatitis	☐	☐		☐	
MUSCULOSKELETAL					
Muscle Weakness	☐	☐		☐	
Trouble Walking	☐	☐		☐	
Osteopenia	☐	☐		☐	
Osteoporosis	☐	☐		☐	
Osteoarthritis	☐	☐		☐	
Chronic Back Pain	☐	☐		☐	
Arthritis/Joint Pain	☐	☐		☐	

Bone Fracture	☐	☐		☐	

MENARCHE HISTORY:
N/A: ☐
~~Menses Type: Regular or Irregular Average menses length:_____days Menses Interval _____days~~
When was your last menstrual period?_____
Comment:_____
Age you started your period (Menarche onset):_____
Age you stopped your period (Menopause onset): _____

CONTRACEPTION HISTORY/USE: (Birth control Pill, condoms, IUD, Injection, Patch, Diaphragm, NuvaRing, Implant, etc.)

1._____ (start)_____(stop)_____(why)_____
2. ._____(start)_____(stop)_____(why)_____
3. ._____(start)_____(stop)_____(why)_____

HABIT/SOCIAL HISTORY

✧ Smoking Status ☐Every day ☐Some Days ☐Former Smoker ☐Never Smoked
Number of packs per day:_____Number of years smoking:_____

✧ Alcohol Use ☐Never ☐Occasionally ☐Daily
Amount per week:_____Type of alcohol:_____

✧Drug Use ☐Never ☐Occasionally ☐Daily
Drug Type:_____Frequency:_____

✧Occupation:_____

✧Highest Level of Education: ☐High School ☐College ☐Graduate Degree

SURGICAL HISTORY-Please check all that apply:

☐NONE
☐Appendectomy
☐Wisdom Teeth
☐Breast Enlargement
☐Breast Reduction
☐Breast Biopsy
☐Breast reconstruction
☐Hysterectomy
☐Ovaries Removed LEFT RIGHT BOTH
☐Gall Bladder Removed
☐Adenoidectomy
☐Tonsillectomy
☐C-Section
☐Tubal Ligation
☐Prostate Removed

DATE/AGE:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____Date of Birth:_____

FAMILY HISTORY

This applies to 1st and 2nd Generation family members only (i.e.: Mother, Father, Siblings, Paternal Parents, Maternal Parents, Paternal Siblings, Maternal Siblings) Please label which side of family as well. (i.e. Mom's sister is Maternal Aunt) For deceased relatives, please give age at time of death and cause of death.

☐NONE APPLIES

☐NOT AWARE OF FAMILY HISTORY

DISEASE OR OTHER MEDICAL CONDITIONS	WHICH FAMILY MEMBER	AGE OF DIAGNOSIS	ALIVE OR DECEASED (If Deceased age at death)
Breast Cancer			☐ Alive ☐Deceased Age:_____
Prostate Cancer			☐ Alive ☐Deceased Age:_____
Ovarian Cancer			☐ Alive ☐Deceased Age:_____
Uterine Cancer			☐ Alive ☐Deceased Age:_____
Colon Cancer			☐ Alive ☐Deceased Age:_____
Other Cancer: _____			☐ Alive ☐Deceased Age:_____
Heart Disease			☐ Alive ☐Deceased Age:_____
Heart Attack			☐ Alive ☐Deceased Age:_____
Diabetes			☐ Alive ☐Deceased Age:_____
Asthma			☐ Alive ☐Deceased Age:_____
Mental Illness			☐ Alive ☐Deceased Age:_____
High Blood Pressure			☐ Alive ☐Deceased Age:_____
Stroke			☐ Alive ☐Deceased Age:_____
Kidney Disease			☐ Alive ☐Deceased Age:_____
Alcoholism			☐ Alive ☐Deceased Age:_____
Substance abuse			☐ Alive ☐Deceased Age:_____

PERSONAL SAFETY –Patient Only (Please check any that apply)

- **Has anyone close to you ever threatened you? ☐ Yes ☐ No**
- **Has anyone ever hit, kicked, choked or hurt you physically? ☐ Yes ☐ No**
- **Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No**
- **Are you afraid of your partner? ☐ Yes ☐ No**

MEDICARE "HIGH RISK" CRITERIA – TO BE COMPLETED BY MEDICARE RECIPIENTS ONLY

- **Have you had a pap smear in the last 7 years? ☐ Yes ☐ No**
- **Have you ever had an abnormal pap smear? ☐ Yes ☐ No**
- **Did you begin sexual activity before you were 16 years old? ☐ Yes ☐ No**
- **Have you had more than five (5) sexual partners in your lifetime? ☐ Yes ☐ No**
- **Have you ever tested positive for the HPV virus? ☐ Yes ☐ No**
- **Did your mother take the drug DES when she was pregnant with you? ☐ Yes ☐ No**

CONSENT TO RELEASE HEALTH INFORMATION

By signing this form, I grant permission to David J. Cox, M.D. to allow the following individuals listed below to have access to all medical information contained in my health record as well as my accounting information. I understand that this consent will remain in effect unless revoked by me in writing.

INDIVIDUAL'S NAME	RELATIONSHIP

Patient Name: _____Date of Birth: _____
(PRINT NAME)

Signature:_____Date: _____

E-BILLING AUTHORIZATION

By signing this form, I grant permission to Eclinical (billing department for David J. Cox, M.D.) to send my statement in the form of an e-mail.

☐ Yes, Please send my account statement to my e-mail address
☐ NO, Please continue to send my account statement through the postal service.

Patient Name: _____E-Mail _____
(PRINT NAME)
Signature:_____Date: _____

RELEASE OF PROTECTED HEALTHCARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICEMAIL

I give my consent and authorization for the medical and billing staff of David J. Cox, M.D. to leave protected healthcare information (PHI) about me on my answering machine or voicemail via telephone at the number(s) listed below. I understand that I may revoke this permission at any time by submitting my request in writing to this office. If I choose not to authorize release via the telephone, I understand that I am responsible for calling the office to retrieve results of all tests and procedures.

Phone Number: _____ HOME
_____ WORK
_____ CELL
_____ OTHER

Release of PHI via telephone authorized: _____
SIGNATURE

Release of PHI via telephone <u>NOT</u> authorized: _____
SIGNATURE

HIPAA PROTECTION INFORMATION

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a medical problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called *The Health Insurance Portability and Accountability Act* (HIPAA). HIPAA regulations cover physicians and all other health care providers, health insurance companies, and their claims processing staff. In general, HIPAA was enacted to establish national standards to give patients more control over their health information; set boundaries for the use and release of health records; establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information; hold violators accountable with civil and criminal penalties; and try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

HIPAA rules require that our practice provide all of our patients seen after April 14, 2003 with our *Notice of Privacy Practices*. The notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information. A copy of our Notice of Privacy Practices can be found at the reception desk for your review. You are entitled to a personal copy of the notice at any time to review and keep for your personal copy of the notice at any time to review and keep for your personal records. If you would like a copy of the notice to keep for your personal records, please request a copy from our front desk receptionist.

By signing below, I acknowledge that I have been given the opportunity to review and/or have received a copy of the *Notice of Privacy Practices*.

PATIENT NAME: _____DATE OF BIRTH:_____
PRINT NAME

SIGNATURE: _____DATE: _____

PERRY INTERNAL MEDICINE
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OFFICE POLICIES AND INFORMATION

Office Hours:
MONDAY, - THURSDAY
9:00 AM – 5:00 PM, closed NOON -1:30 PM for lunch
Friday
8:00 – 12:00 PM

After-hours access to our staff is available by calling 478-988-0022 and following the voicemail message instructions.
Effective, July 1, 2013 insurance co-pays are due at sign-in along with any outstanding past due balances. If you are unable to make your co-payment upon arrival, you may or may not be seen at the physician's discretion.
Effective, January 1, 2013, the "no-show" fee will increase to $35.00. A no-show fee will be charged for all missed appointments unless our office is given 24 hour's notice that you will not be able to make your appointment time. Exceptions to this policy for extenuating circumstances will be made at the physician's discretion.
Any patient who arrives significantly late for their appointment will be charged a no-show fee and rescheduled for a later date. Exceptions to this policy for extenuating circumstances will be made at the physician's discretion.
24-hours' notice is required for all prescription refills.

Claims for services provided will be filed with the patient's health insurance company as a courtesy to the patient. Please remember that health insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitute for payment. Some health insurance companies pay a fixed allowance for procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by the patient's insurance company. In order to control the patient's cost of billings, we request that our charges for office visits be paid prior each visit unless prior arrangements have been made. In addition, it is the patient's responsibility to notify the staff of any changes in insurance as there are timely filing limits to most all insurances. All patient accounts that are more than 90 days past-due will be sent to collections and the patient's medical treatment will be terminated. If a patient's account is assigned for collection, the patient will be responsible for all attorneys' fees and any other costs of collection.

By signing below, I hereby authorize David J. Cox, MD to release all information (including HIV, substance abuse, and psychiatric information) which may be found in my health record and is necessary to secure payment. I request that payment of authorized benefits be made on my behalf. I assign the benefits to insurance, major medical benefits and other health benefits to David J. Cox, MD. I understand that this assignment will remain in effect until revoked by me in writing. I agree that a photocopy of assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I acknowledge that I have read this form carefully and accept all policies outlined within. By signing below, I acknowledge that I fully understand all of my obligations.

PATIENT NAME:_____DATE OF BIRTH:_____

SIGNATURE:_____DATE:_____