Atlanta Infectious Disease Specialists, PC

Patient Information

Last Name | First Name | MI | DOB | Sex | SS#

Address | City | State | Zip | Home Phone

Employment Status Employed □ FT Student □ PT Student □ N/A □ Employer | Title | Cell Phone

Work Address | City | State | Zip | Work Phone

Name of Person Responsible for Making Healthcare Decisions for You | Resp Party Phone

Marital Status Single □ Married □ Other □ email:

Referring Physician Information

Last Name | First Name | MI | Address | Phone

Primary Care Physician Information

Last Name | First Name | MI | Address | Phone

Do You Require a Referral for Office Visits **YES** □ No □ Do you have a Current Referral Yes □ No □ **Referral #**

In Case of Emergency Call

Last Name | First Name | MI | Address | Home Phone

Relationship | Cell Phone

Responsible Party Statement

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Signature | Print Name - - - - - > | Date

Welcome to Atlanta Infectious Disease Specialists, PC (*www.atlidspec.com*)

We are happy to further extend our services by filing your insurance for you. Please select your payment -

Please pay the balance in full at the time of service. Or contact us prior to your visit.	□ Self Pay
We will bill your Workers Comp Carrier. Note you do remain financially responsible for all charges, if your carrier denies coverage or your claims are controverted.	□ Workers Comp
We will bill your primary and secondary insurance. However, charges that remain outstanding after 45 days, will be the responsibility of the patient.	□ Insurance

We're here to help! Please furnish our office with your most current insurance information.

Assignment of Benefits / Authorization to Release Medical Information / Consent to Treat

Hereby assign all medical benefits to which I am entitled to Atlanta Infectious Disease Specialists, PC, in the event they file insurance on my behelf. I understand that I am financially responsible for all charges, whether or not paid by said insurance. In the event my account becomes delinquent and is, therefore, in default of payment, I accept responsibility for the principal amount owing as well as all reasonable cost associated with the collection of this debt, including, buit not limited to collection service fees, attorney fees and all court costs and additional legal fees associated with the recovery of this debt. A service charge or interest may be charged at the rate of 1.5% per month (18% annually) for unpaid balances over forty-five (45) days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.
I do hereby consent to such treatment by the authorized personnel of Atlanta Infectious Disease Specialists, PC, as may be dictated by prudent medical practice by my illness, injury or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature, Date

MR# _____

Atlanta Infectious Disease Specialists, P.C.
Comprehensive Patient History

Patient name: _____ Date of Birth _____ Date: _____

What is the reason for today's visit? _____

Describe the following:

Location: _____ How long have you had this problem? _____

How severe is this problem? ❑ mild ❑ moderate ❑ very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

Provider Comments: ❑ I have confirmed the above information with the patient and the following are any additional comments: _____

_____

List previous hospitalizations/Surgeries/Serious Injuries When?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient Social History

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily _____

Use of tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day _____

Use of Drugs: ❑ Never ❑ Type/Frequency _____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise

List any allergies you have.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Have you ever had the following?								
Cancer	yes	no	Diabetes	yes	no	Hypertension	yes	no
Arthritis/Gout	yes	no	Stroke	yes	no	Heart trouble	yes	no
Acute Infections	yes	no	Convulsions	yes	no	Bleeding Tendency	yes	no
			Venereal Disease	yes	no	Hereditary Defects.....	yes	no

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
	____	_____	_____
	____	_____	_____
Mother	____	_____	_____
	____	_____	_____
	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____

Have you recently experienced any of the following?

PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL			Date
Good general health lately	No	Yes	
Recent weight change	No	Yes	
Fever	No	Yes	
Fatigue	No	Yes	
Headaches	No	Yes	
EYES			
Eye disease or injury	No	Yes	
Wear glasses/contact lens	No	Yes	
Blurred or double vision	No	Yes	
Glaucoma	No	Yes	
ENT			
Hearing loss	No	Yes	
Ringing in the ears	No	Yes	
Earaches or drainage	No	Yes	
Sinus problems	No	Yes	
Nose bleeds	No	Yes	
Mouth sores	No	Yes	
Bleeding gums	No	Yes	
Bad breath or bad taste	No	Yes	
Sore throat or voice change	No	Yes	
Swollen glands in neck	No	Yes	
CARDIOVASCULAR			
Heart trouble	No	Yes	
Chest pains	No	Yes	
Sudden heart beat changes	No	Yes	
Swelling of feet, ankles or hands	No	Yes	
RESPIRATORY			
Frequent coughing	No	Yes	
Spitting up blood	No	Yes	
Shortness of breath	No	Yes	
Asthma or wheezing	No	Yes	
GASTROINTESTINAL			
Loss of appetite	No	Yes	
Change in bowel movements	No	Yes	
Nausea or vomiting	No	Yes	
Frequent diarrhea	No	Yes	
Painful bowel movements or constipation	No	Yes	
Blood in stool	No	Yes	
Stomach pain	No	Yes	
GENITOURINARY			
Frequent urination	No	Yes	
Burning or painful urination	No	Yes	
Blood in urine	No	Yes	
Change of force of strain when urinating	No	Yes	
Incontinence or dribbling	No	Yes	
Kidney stones	No	Yes	
Male – testicle pain	No	Yes	
Female – pain with periods	No	Yes	
Female – irregular periods	No	Yes	
Female – vaginal discharge	No	Yes	

Female – # pregnancies_____ # miscarriages_____

Female – date of last pap smear_____

Female – findings of last pap smear ❑ Normal ❑ Abnormal

MUSCULOSKELETAL			Date
Joint pain	No	Yes	
Joint stiffness or swelling	No	Yes	
Weakness of muscles or joints	No	Yes	
Muscle pain or cramps	No	Yes	
Back pain	No	Yes	
Cold extremities	No	Yes	
Difficulty in walking	No	Yes	
SKIN			
Rash or itching	No	Yes	
Change in skin color	No	Yes	
Change in hair or nails	No	Yes	
Varicose veins	No	Yes	
Breast pain	No	Yes	
Breast lump	No	Yes	
Breast discharge	No	Yes	
NEUROLOGICAL			
Frequent or recurring headaches	No	Yes	
Light headed or dizzy	No	Yes	
Convulsions or seizures	No	Yes	
Numbness or tingling sensations	No	Yes	
Tremors	No	Yes	
Paralysis	No	Yes	
Stroke	No	Yes	
PSYCHIATRIC			
Memory loss or confusion	No	Yes	
Nervousness	No	Yes	
Depression	No	Yes	
Sleep problems	No	Yes	
ENDOCRINE			
Glandular or hormone problem	No	Yes	
Thyroid disease	No	Yes	
Excessive thirst or urination	No	Yes	
Heat or cold intolerance	No	Yes	
Dry skin	No	Yes	
Change in hat or glove size	No	Yes	
HEMATOLOGIC/LYMPHATIC			
Slow to heal after cuts	No	Yes	
Easily bruise or bleed	No	Yes	
Anemia	No	Yes	
Phlebitis	No	Yes	
Past transfusion	No	Yes	
Enlarged glands	No	Yes	

List <u>any</u> prescription drugs, OTC meds, or herbals or supplements you are currently taking.

_____

_____

_____

_____

❑ History was filled out by other than patient. Print Name and relationship: _____

Patient Signature:_____ Patient Signature:_____/ date _____

Patient Signature:_____

❑ I have reviewed and confirmed this information with the patient. Provider Signature:_____/ date _____