



# VININGS MEDICAL CENTER

2255 Cumberland Pkwy, Bldg 1400 - Atlanta, GA 30339

## New Patient Registration

Thank you for visiting Vinings Medical Center. In order to generate your medical record, please complete this and all attached forms in their entirety. Feel free to let us know if you have any questions while completing the forms.

### Patient Information

\_\_\_\_\_  
*Patient name (Last, First)*

\_\_\_\_\_  
*Patient date of birth*

\_\_\_\_\_  
*Patient gender (M / F)*

\_\_\_\_\_  
*Patient marital status*

\_\_\_\_\_  
*Mailing address (address number & street)*

\_\_\_\_\_  
*Patient Social Security Number*

\_\_\_\_\_  
*Employment / student status*

\_\_\_\_\_  
*Mailing address (apartment no., etc.)*

\_\_\_\_\_  
*Employer or school name*

\_\_\_\_\_  
*City, State, ZIP Code*

\_\_\_\_\_  
*Work telephone (include extension)*

\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*When we need to leave a message which number may we use?*

\_\_\_\_\_  
*E-Mail address*

\_\_\_\_\_  
*Do you have a living will?*

\_\_\_\_\_  
*Would you like information on one?*

### Guarantor Information (skip if same as patient)

*(The guarantor is the person holding your insurance plan or individual responsible for payment)*

\_\_\_\_\_  
*Guarantor name (Last, First)*

\_\_\_\_\_  
*Guarantor date of birth*

\_\_\_\_\_  
*Guarantor gender (M / F)*

\_\_\_\_\_  
*Mailing address (address number & street)*

\_\_\_\_\_  
*Guarantor Social Security Number*

\_\_\_\_\_  
*Mailing address (apartment no., etc.)*

\_\_\_\_\_  
*Relationship to patient*

\_\_\_\_\_  
*City, State, ZIP Code*

\_\_\_\_\_  
*Work telephone (include extension)*

\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*Employer name*

\_\_\_\_\_  
*E-Mail address*

\_\_\_\_\_  
*May we leave a message at work?*

### Emergency Contact Information

\_\_\_\_\_  
*Name (Last, First)*

\_\_\_\_\_  
*May we disclose necessary medical information to this person?*

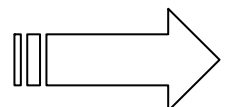
\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*Your relationship to this person*

\_\_\_\_\_  
*Work telephone (include extension)*

**Next page, please**



## Primary Insurance Information

Insurance company name \_\_\_\_\_

Relationship of patient to insured:  Self  Spouse  Dependent Child  Other: \_\_\_\_\_

## Secondary Insurance Information

Insurance company name \_\_\_\_\_

Relationship of patient to insured:  Self  Spouse  Dependent Child  Other: \_\_\_\_\_

## Pharmacy Information

Pharmacy name and address \_\_\_\_\_

Pharmacy Telephone \_\_\_\_\_

## Payment Policies, Miscellaneous Terms:

1. APPOINTMENT NO-SHOW, CANCELLATION, AND LATE ARRIVAL POLICY (this policy became necessary to preserve access for our established patients):
  - a. I understand Vinings Medical Center requires a twenty-four hour notice of cancellation for any appointment.
  - b. Should I fail to provide such notice I agree to pay \$75.00 (\$125.00 for physicals) in consideration for my lack thereof. Additionally, if the appointment was scheduled less than twenty-four hours before the appointment itself I agree to pay \$75.00 in the event I cancel or no-show.
  - c. Notice to new patients: If a new patient no-shows, shows up late, or calls the day of their new patient appointment to reschedule (regardless if calling before or after the scheduled appointment time) that patient will not be allowed to establish with the practice under any circumstances.
  - d. I understand my insurer will not pay fees associated with no-shows and late cancellations.
  - e. I understand two or more no-shows, late cancellations, or repeated late arrivals for appointments will result in dismissal from the practice.
2. ADMINISTRATIVE SERVICES: Forms requiring completion outside a face-to-face, billable, in-office visit with a Physician will incur a \$25.00 per form administrative processing fee which is payable before we are able to process your form(s). This administrative processing fee covers specific administrative services which your insurer does not cover. Examples include but are not limited to forms required by: Family Medical Leave Act (FMLA), disability, life insurance, marriage license, foreign travel, adoptions, health clubs, letters for employers (other than simple work excuse letters), camps and schools (not including sports and camp physical forms related to a physical performed in our office), and any miscellaneous letters or forms requested by the patient.
3. MAINTENANCE OF CONTACT INFORMATION: I understand the practice will use the last address of record to contact me. I understand it is my responsibility to maintain current contact information with the practice.
4. WEIGHT CONTROL MEDICATIONS: I understand Vinings Medical Center Physicians do not prescribe medications for weight loss. If I request or require (now or in the future) medically-managed weight control I understand I will be referred to the appropriate specialist.
5. DELIVERY OF LAB RESULTS: I understand the practice uses a secured, online lab results delivery system to advise lab results and adjustments to medication which are based on lab results; I understand and agree it is my responsibility to use this system to obtain my lab results.
6. PCP ELECTION: If my insurance company requires a PCP election, I have selected Dr. Smith as my (or my dependent's) PCP. The effective date of this change as stated by my insurer is on or before the date of my (or my dependent's) first visit.
7. CO-PAYMENT, COINSURANCE, AND DEDUCTIBLE POLICY: I understand Vinings Medical Center, P.C. requires payment at time of service for any amount not covered by insurance (including but not limited to co-payments, co-insurance, unmet deductibles, non-covered services, etc.).
8. CLAIMS FILING AGREEMENT AND ASSIGNMENT OF BENEFITS: I authorize Vinings Medical Center, P.C. to file insurance claims on behalf of the Patient and I assign associated benefits to Vinings Medical Center, P.C..
9. MEDICARE INSURANCE: The practice has opted-out of Medicare and does not accept Medicare insurance. This status is reevaluated annually.
10. FINANCIAL AGREEMENT: I am ultimately responsible for payment of all sums owed Vinings Medical Center, P.C. relating to services provided to the patient identified herein. I understand and agree I must pay all charges on the Patient's account which are not covered by insurance, including, but not limited to co-payments, deductibles, co-insurance, PCP changes taking effect after Patient's office visit, and charges which insurance fails to pay or refuses to cover. I understand and agree that I will pay all sums within thirty days of initial invoice date and that sums not paid within this time shall incur a \$5.00 rebilling fee (per additional billing notice) and accrue interest from the original date(s) of service at the rate of 1.5% per month. In the event sums owed are not paid when due, I understand and agree that I will be responsible for all costs incurred by Vinings Medical Center, P.C. in the collection of sums owed on the Patient's account, including collection agency fees, attorney fees, and court costs, if applicable. I further acknowledge: a) I will incur a service charge of \$35.00 for each check not honored by my financial institution and I agree to pay the amount of the returned check plus the service charge within seven days of notification of the dishonored check; b) any returned check on a self-pay account which received a self-pay at time of service discount will have this discount reversed; and c) no additional credit will be extended to a patient or guarantor when a balance is past-due on their account(s).
11. PRIVACY PRACTICES: I may review Vinings Medical Center, P.C. Notice of Privacy Practices at any time.
12. AUTHORIZATION TO TREAT: I give Dr. Smith, Vinings Medical Center, its agents, employees, and contractors authorization to treat the patient listed herein.

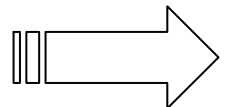
I have read, understand and agree to these terms.

Signature of Patient or Patient's Responsible Party \_\_\_\_\_

Patient or Patient's Responsible Party Name (please print) \_\_\_\_\_

Today's Date \_\_\_\_\_

**On to privacy form, please**





## Consent to Use and Disclosure of Protected Health Information

We are providing you this notice in accordance with applicable law. If you have any questions, please feel free to let us know.

- 1. Use and Disclosure of Your Protected Health Information:**  
Your protected health information will be used by Vinings Medical Center, P.C. and may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.
- 2. Notice of Privacy Practices:**  
Upon request you may review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.
- 3. Requesting a Restriction on the Use or Disclosure of Your Information:**  
You may request a restriction on the disclosure of your protected health information as described in paragraph one. Vinings Medical Center, P.C. will advise in writing if it agrees to your request as it may interfere with our ability to receive payment from your insurance company. If Vinings Medical Center, P.C. agrees to your request, the restriction will be binding. Thereafter, subject to the terms set forth in the restriction agreement, use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.
- 4. Revocation of Consent:**  
You may revoke this consent; however any such request must be made in writing and is subject the terms and conditions of paragraph three. Any use or disclosure that occurred prior the date on which your revocation of consent is received will not be subject to your requested revocation.
- 5. Reservation of Right to Change Privacy Practices:**  
Vinings Medical Center, P.C. reserves the right to modify its Notice of Privacy Practices from time to time without notice.

In signing below, I confirm I have reviewed this consent form and give permission to Vinings Medical Center, P.C. to use and disclose my health information in accordance with the terms stated herein.

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Signature of Patient or Legal Guardian

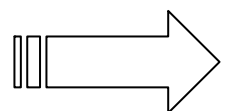
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Name of Patient (please print)

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Today's Date

***On to history form, please***





## New Patient Medical History

Your thorough completion of this form is very important as it assists us in understanding your current and historical medical status. If you have any questions when completing this form, please let us know.

### Patient Information

\_\_\_\_\_  
 Patient name (Last, First)

\_\_\_\_\_  
 Patient date of birth

\_\_\_\_\_  
 Today's Date

### Current Prescription Medications

Name of Drug	Dose (i.e., 100mg)	Frequency (i.e., once / day)

Name of Drug	Dosage (i.e., 100mg)	Frequency (i.e., once / day)

### Other Medications (Includes Over-the-counter, Herbs, Supplements, Vitamins, Minerals)

Name of Medication	Dose (i.e., 100mg)	Frequency (i.e., once / day)

Name of Medication	Dosage (i.e., 100mg)	Frequency (i.e., once / day)

### Drug & Food Allergies

I am not allergic to any medications

I am allergic to penicillin  My reaction is: \_\_\_\_\_

I am allergic to sulfa  My reaction is: \_\_\_\_\_

I am allergic to codeine  My reaction is: \_\_\_\_\_

I am allergic to shellfish or iodine  My reaction is: \_\_\_\_\_

I am allergic to latex  My reaction is: \_\_\_\_\_

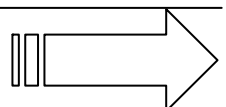
Additional medications I am allergic to:	The reaction I had was:

Foods I am allergic to include:	The reaction I had was:

### Medical Conditions – Indicate if you have (or ever had) any of the following:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Hepatitis or jaundice    | <input type="checkbox"/> Cancer (any type)             |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Liver / pancreas disease | <input type="checkbox"/> Received blood transfusion    |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Kidney stone(s)          | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Other kidney disease     | <input type="checkbox"/> Positive HIV or AIDS          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Urinary tract infection  | <input type="checkbox"/> Abnormal PAP                  |
| <input type="checkbox"/> Anemia              |  |   |  |

Others (please describe): \_\_\_\_\_



**Surgical History - Indicate if you ever had any of the following (also list the year):**

- Appendix – year:                       Gall bladder – year:                       Thyroid – year:                       Hysterectomy – year:  
 Hernia – year:                       Heart – year:                       Lung – year:                       Spine or any joint – year:  
 Tonsils – year:

Others (please describe): \_\_\_\_\_

**Hospitalizations – List all other than those listed in above surgical history and childbirth:**

Year	Reason

Year	Reason

**Your Social History:**

I drink \_\_\_\_ cups/glasses/cans of caffeinated coffee, tea, or soda per day

Do you smoke now:  yes  no    Smoked in the past:  yes  no

How many years: \_\_\_\_\_    Year quit smoking: \_\_\_\_\_

Other tobacco products I use include:

- None    Cigars    Chewing tobacco    Snuff    Other

Alcohol usage – I drink the following number of drinks per week:

- None    1-7    8-14    14+

Do you participate in recreational drug use:  yes  no

If so, I use: \_\_\_\_\_

My occupation is: \_\_\_\_\_

I have traveled out of the country in the last year:  yes  no

If so, I went to: \_\_\_\_\_

Do you have pets at home?  yes  no

If so, I have:  Dogs    Cats    Birds    Other: \_\_\_\_\_

Do you exercise regularly?  yes  no

Have you signed your driver's license as an organ donor?  yes  no

**Family History – Check off where applicable (blood relatives only):**

	Living?	Age	High Blood Pressure	Heart Disease	Stroke	High Cholesterol	Diabetes	Any form of cancer	Other (please list)
Father	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Any other information you believe we should know:**

**All done...  
Thank you!**