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Patient Registration Form

Patient Name: ____ D.O.B:______________________________

Social Security Number:_________________________________ Sex: □ Male □ Female

Marital Status: □ Married □ Widowed □ Single □ Divorced □ Partnered

Race: ____________________ □ Hispanic □ Non-Hispanic Language: ________________________

Address: ____ City/State/Zip: _______________________

Home Phone: _______________ Cell Phone: _________________ Work Phone: _____________________

Patient Employer:_______________________________________ Employer Phone #_________________

Email Address: ____________________________ Pharmacy:_____________________________________

Primary Care Physician: ________________________________ Phone: _____________________________

Referring/ Other Physician: _____________________________ Phone: _____________________________

Reason for today's appointment: ____

Health Information Release:

I authorize Macon Medical Group to release information about my health to the following person(s) listed below. Please note that unless listed below, they will not have access to your medical record, including your spouse.

1. Name: _______________________________ Relationship: __________________________________

   Address: ______________________________ Phone: ____

2. Name: _______________________________ Relationship: __________________________________

   Address: ______________________________ Phone: ____

3. Name: _______________________________ Relationship:__________________________________

   Address: ______________________________ Phone: ____

I understand that the people listed above will have access to my medical record. I understand that if in the future this list changes that I am solely responsible for making any necessary changes.

____ ___________________

Beneficiary/ Authorized Representative Signature Date

PATIENT NAME:____ **DATE:**_____________

MEDICAL HISTORY

Allergies:

______________________ **Reaction:** ____

______________________ **Reaction:** ____

______________________ **Reaction:** ____

Social History:

Occupation/Former Occupation: ____

Tobacco use? ○ YES ○ NO - If YES, how many cigarettes per day? _________ How long?___________

Caffeine use? ○ YES ○ NO - If YES, how many cups per day? _________________ How long?__________

Alcohol use? ○ YES ○ NO - If YES, how many drinks per week? _______________ How long?____________

Recreational drugs? ○ YES ○ NO - If YES, what type? ____________ How long?________ How much?_____

Family History:

Father: Living? □ Yes, Medical Conditions:_______________________________________
□ No, Cause of Death: ____
Mother: Living? □ Yes, Medical Conditions:_______________________________________
□ No, Cause of Death: ____

Other medical problems within the family: ____

Nutritional:

What type of food and beverages do you consume each day? *(Please fill in sample meals below)*

Morning: ____

Lunch: ____

Dinner: ____

Snack/ Other: ____

Review of Systems:

General:	Yes	No		Ear, Nose & Throat:	Yes	No
Weight Change in the last 6 months?				Coughing?		
Loss of Appetite?				Nosebleeds?		
Fever?				Hearing Loss?		
Weakness?				Sore Throat?		
Fatigue?				Ringing in the Ears?		
Gastroenterology:	**Yes**	**No**		Sinus Pain?		
Mouth Dryness?				Pain/Difficulty in Swallowing?		
Blood in/ Black Stool?				Runny Nose?		
Nausea?				Itchy Eyes?		
Heartburn?				Ear Fullness?		
Abdominal Pain?				**Respiratory:**	**Yes**	**No**
Diarrhea?						
Constipation?				Difficulty breathing lying down?		
Hemorrhoids?				Shortness of Breath?		
Cardiology:	**Yes**	**No**		Chest Congestion?		
Dizziness?				**Muscoskeletal:**	**Yes**	**No**
Chest Pain?				Neck Pain?		
Palpitations?				Back Pain?		
Leg Edema?				Muscle Aches?		
Varicose Veins?				Shoulder Pain?		
Endocrinology:	**Yes**	**No**		Gout?		
Heat Intolerance?				Joint Pain/Stiffness?		
Excessive Thirst?				Joint Swelling?		
Diabetes?				Leg Cramps?		
Cold Intolerance?				Osteoporosis?		

Urology:	Yes	No		Neurology:	Yes	No
Kidney Stones?				Numbness?		
Foamy Urine?				Difficulty Concentrating?		
Difficulty Urinating?				Difficulty Comprehending?		
Blood in Urine?				Weakness?		
Frequent Urination?				Headache?		
Loss of Bladder Control?				Tingling/Numbness?		
Recurrent UTI?				Seizures?		
Night Time Urination?				Insomnia?		
Male:				Memory Loss?		
Erectile Dysfunction?				Abnormal Gait?		
Prostate Problems?				**Dermatology:**		
Female:				Itching?		
Vaginal Discharge?				Sweating?		
Vaginal Bleeding?				Hair Loss?		
				Rash?		
				Dry/Sensitive Skin?		

Is there any other information you wish to disclose?

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____

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my physician if I ever have a change in my health status.

____
Printed Name of Patient & Authorized Patient Representative

____ _______________
Signature of Patient/ Authorized Patient Representative Date

Billing & Insurance Information:

Payment Method: ○ Insurance ○ Self-pay (If self-pay, please continue to Patient-Practice Policies)

Primary Insurance:

Policy Holder: ____________________________________ D.O.B:_____________

Social Security #:_________________________________ Relationship to Patient:_______________

Insurance Company: _____________________________

Policy Number: ___________________________________ Group Number:_____________________

Is patient covered by additional insurance? ○ YES ○ NO (If YES, please continue)

Secondary Insurance:

Policy Holder:____________________________________ D.O.B:_____________

Social Security #:_________________________________ Relationship to Patient:_______________

Insurance Company: _____________________________

Policy Number:___________________________________ Group Number:_____________________

Is patient covered by additional insurance? ○ YES ○ NO
(If YES, patient does have Tertiary Insurance information, we will obtain a copy of your insurance card.)

Assignment & Release:

I, _________________________________, have insurance coverage with the company(s) listed above, and assign and authorize payment directly to Macon Medical Group and/or the providers at Macon Medical Group all medical benefits, if any otherwise payable to me for services rendered.

I understand and acknowledge that this Assignment does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Macon Medical Group, by any insurance policy, self-insurance program or other benefit plan.

I hereby authorize the doctor to release of all information necessary to secure the payment of benefits, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, and any health care related utilization review or quality assurance activities or any health care professional requiring this information.

I also authorize Macon Medical Group to file appeals on my behalf to insurance companies for payment of claims. I authorize the use of this signature on all my insurance claim submissions. Lastly, I acknowledge that this authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I further understand that I have the right to receive a copy of this authorization.

_______________________________________ _________________

Patient Signature Date

Medicare/Medigap Authorization:

Medicare ID Number: ____________________________

I request that payment of authorized Medicare benefits and, if applicable Medicare Supplemental benefits, be made on my behalf to Macon Medical Group and/or the providers at Macon Medical Group for any services furnished to me by them. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medicare Supplemental insurer, and their agents any information needed to determine these benefits or benefits for related services.

____ ___________________

Beneficiary/ Authorized Representative Signature Date

If Authorized Representative:

____ ______________________ ____________________

Authorized Representative Name Relationship Phone

____ _____________________

Address City/State/Zip

Consent of Treatment

Macon Medical Group (MMG) employs a team approach to the delivery of your health care. Throughout your treatment we will work to understand your current nephrology and hypertension treatment needs. In order to accomplish this, an initial evaluation is completed and information is collected about the problems you may be experiencing. Upon the completion of any additional diagnostic testing, a follow-up evaluation will be scheduled and a course of treatment will be provided.

Medical services will be provided not only by your primary Nephrologist, but all Nephrology Physicians, Physician Assistants, Nurse Practitioners, Nurses and Medical Assistants employed by MMG. Medical services and treatments modalities include evaluation and management services, diagnostic ultrasound, laboratory testing, nutritional counseling, educational classes and pharmaceutical therapies.

MMG may refer you to a treatment provider for other services that we believe are necessary at any time. WE will assist you in coordinating these services in order to ensure that you receive the quality and timely services that you are entitled to receive.

Your signature below acknowledges that you understand and agree to the following:

- I am giving my consent to be seen and evaluated by the Providers of MMG. I understand that all medical staff employed by MMG are under the direct supervision of the Physicians at MMG.
- I acknowledge that I have been informed of my rights under Georgia Law to have my prescriptions given to me by a Nurse Practitioner/ Physician Assistant reviewed by my Nephrologist before filling it at the pharmacy, if I chose to do so.
- I have chosen to receive medical services from MMG. I understand that my choice has been voluntary and that I may terminate treatment at any time. I also understand that there is no assurance I will feel better.
- I also understand that my treatment is a collaborative effort between myself and MMG, and that I will attempt to work with MMG, to develop and follow a plan of treatment, and have the right to make an informed decision whether to accept or refuse treatment.

____ __________________

Beneficiary/ Authorized Representative Signature Date