INNOVATIONMD

PATIENT REGISTRATION FORM

Date:

LAST NAME	FIRST NAME	MIDDLE NAME

BIRTH DATE (mm/dd/yyyy)	SEX ❑ Male ❑ Female	I IDENTIFY MYSELF AS: ❑ Male ❑ Female ❑ Other: _____	PHARMACY

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	MOBILE PHONE	E-MAIL ADDRESS

MARITAL STATUS	INTERPRETER NEEDED?	PREFERRED LANGUAGE	RACE	ETHNICITY
❑ M ❑ S ❑ D ❑ W	❑ Yes ❑ No		❑ Black ❑ White ❑ Asian ❑ Other	❑ Hispanic ❑ Non-Hispanic

COMMUNICATION PREFERENCE ❑ Mail ❑ Phone ❑ Email ❑ Patient Portal	PRIMARY CARE PHYSICIAN

EMPLOYER INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE

BUSINESS ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	MOBILE PHONE

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GUARANTOR'S NAME	RELATIONSHIP

ADDRESS (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH	SEX

EMPLOYER	HOME PHONE	WORK PHONE	MOBILE PHONE

NAME OF ADULT PRESENTING MINOR FOR TREATMENT	RELATIONSHIP

INSURANCE INFORMATION

INSURANCE COMPANY (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER

Who may we thank for referring you to our office?

How did you hear about our office?

We look forward to being a part of your healing and journey to better health!

INNOVATIONMD

Patient Financial Policy

Thank you for choosing Innovation MD to achieve your health goals. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our office manager.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is responsible for the payment for his/her treatment and care before services are rendered.
- Our services are NOT covered by insurances.
- Payment of procedures or treatments is due at the time of service.
- For your convenience, we accept **CareCredit, Visa, MasterCard, American Express, Discover, cash and checks** at our office.
- If an approved payment plan is not paid after 90 days of rendered service, the balance will
- accrue an additional 35% after being submitted to collections.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Innovation MD Management. These charges may include (but not limited to): charges for returned checks charge for missed appointments without 24-hour advance notice charge for the copying and distribution of patient medical records any costs associated with collection of patient balances

Patient Authorizations

By my signature below, I hereby authorize assignment of financial benefits directly to Innovation MD and any associated healthcare entities for services rendered. By my signature below, I authorize communication by Innovation MD personnel via mail, answering machine message, and/or email according to the information I have provided in my patient registration information. I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Patient Name/ Date of Birth:_____

Patient Signature:_____

Date:_____

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PHYSICIAN DISCLOSURE & PATIENT ACKNOWLEDGMENT OF HEALTH SERVICES

Notice to Patients:

Under Georgia Law, a health care provider may not refer a patient for the provision of designated health services to an entity in which the health care provider has an investment interest according to the provisions set forth in O.C.G.A 43-1B-5. The law prohibits me, with certain exceptions, from referring you for designated health services to a facility in which I or any of my immediate family members have a financial interest.

Designated health services as defined by Georgia law include clinical laboratory services, physical therapy services, rehabilitation services, diagnostic imaging services, pharmaceutical services, durable medical equipment, home infusion therapy services (including related pharmaceuticals and equipment), home health care services, and outpatient surgical services.

If exceptions in the law apply, or if I am referring you for services other than those listed above, I can make the referral under the condition that I disclose my financial interest and tell you about alternative providers where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

I, P. Tennent Slack, MD, or my immediate family members have a financial relationship with the following providers: **Northeast Georgia Physicians' Group**

For more information about alternative providers, please ask me or my staff. We will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Patient Name/ Date of Birth:_____

Patient Signature:_____

Date:_____

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New Patient Paperwork

DATE:_____ NAME:_____ DOB:___/___/___ AGE:____

What problem are we seeing you for? _____

How long have you had this problem? _____

Have you had any imaging for your complaint (MRI, X-ray, CT, EMG)? _____

PAST MEDICAL HISTORY (Circle any of the following conditions you have been diagnosed with):

Headaches	High Blood Pressure	Congestive Heart Failure	Anemia
Implanted Devices	Low Blood Pressure	Stomach Ulcers	Epilepsy
Stroke	Syncope	[illegible]	Arthritis
TIA	High Cholesterol	Liver Disease	Fibromyalgia
Carotid Artery Disease	Thyroid Disease	Hepatitis	Psychiatric Disorder
Coronary Artery Disease	Asthma	Kidney Stones	Anxiety
Heart Attack	Emphysema/COPD	Kidney Disease	Depression
Abnormal Heart Rhythm	Cancer	K[illegible]	Claustrophobia

Other:_____

PAST SURGICAL HISTORY (Circle any of the following surgeries you have undergone):

Back Surgery	Carotid Surgery	Carpal Tunnel Repair	Gall Bladder
Neck Surgery	Cardiac Stent	Hysterectomy	Gastric Bypass
Joint Replacement	Pacemaker	Appendectomy	Spinal Cord Stimulator

Other:_____

SOCIAL HISTORY:

Alcohol Use: Yes No Frequency:_____

Tobacco Products: Current Former Never E-cigarettes

Currently working? Yes No Occupation:_____

Disability? Yes No Pending Seeking

Caffeine Beverages per day? _____

Under Stress? Yes No

Marital Status: _____

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list relationship to affected individual(s):

Heart Disease _____	Kidney Disease _____	Psychiatric History _____
Hypertension _____	Neuropathy _____	Drug Abuse _____
Stroke _____	Seizure Disorder _____	Parkinson's Disease _____
Back Surgery _____	Diabetes _____	Arthritis _____
Headaches _____	Brain Aneurysm _____	Trembling _____
Cancer _____	K[illegible]	

REVIEW OF SYSTEMS (Circle any of the following symptoms you have experienced in the past 6 months):

Constitutional

Activity change

Appetite change

Fatigue

Fever

Unexpected weight change

HENT

Congestion

Ear pain

Hearing loss

Nosebleeds

Runny nose

Sinus pain

Sore throat

Ringing in the ears

Difficulty swallowing

Voice change

Eyes

Eye pain

Eye redness

Sensitivity to light

Visual disturbance

Respiratory

Chest tightness

Cough

Shortness of breath

Cardiovascular

Chest pain

Leg swelling

Palpitations

Gastrointestinal

Abdominal distention

Abdominal pain

Constipation

Diarrhea

Nausea

Vomiting

Endocrine

Cold intolerance

Heat Intolerance

Genitourinary

Large volume of urine

Painful urination

Urinary Frequency

Musculoskeletal

Joint pain

Back pain

Difficulty Walking

Joint swelling

Muscle pain

Neck pain

Skin

Color change

Rash

Allergies/Immune System

Food allergies

Immuno-compromised

Neurological

Dizziness

Headaches

Light-headedness

Numbness

Seizures

Speech difficulty

Syncope

Tremors

Weakness

Hematologic

Bruises/bleeds easily

Psychiatric

Agitation

Behavior problem

Confusion

Decreased concentration

Persistent bad mood

Hallucinations

Nervous/anxious

Sleep disturbance

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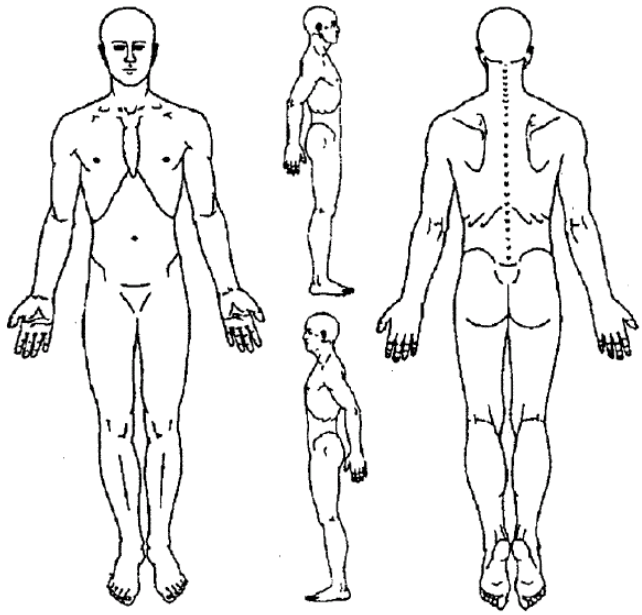
Pain Survey

Name:_____ **Date:**_____

Location: In what part of your body is your pain the worst?_____

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

Aching Burning Cold Electric Shock Dull Hot/Flushed Numb Tingling Stabbing
Sharp Pins & Needles Throbbing Other (describe):_____

Rate the severity of your pain *at its worst* on this scale (1 = mild, 10 = worst pain of your life):

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Radiation/Referral Pattern: Does your pain travel to other locations? Yes No If yes, where?_____

Describe the frequency of your pain. Daily Weekly Monthly Constant Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst?_____

Aggravating Factors: What worsens the pain?_____

Alleviating Factors: What makes the pain better?_____

Activity: Are you exercising, walking, stretching, etc? _____

How Many Hours of Sleep do you average per night?_____ **Would you consider this quality sleep?** Yes No

How would you describe your mood? Irritable Sad Happy most of the time Other:_____

Are you currently working? (Circle one) Full-Time Part-Time Not Currently Working

Medications & Allergies

Name:_____ **Date of Birth:**_____

Retail Pharmacy:_____ **Phone:**_____

Mail-in Pharmacy:_____

Medication Allergies:_____ **Latex Allergy: YES / NO**

Please list all current medications, including dosage and how many times per day you take each medication.

MEDICATION	DOSE	TIMES PER DAY
Example: Tramadol	**50 mg**	**Twice A Day**