SMYRNA FAMILY MEDICINE

REGISTRATION FORM

David Kim, M.D. • Mike Allen, P.A.
3903 S. Cobb Dr. • Suite 200
Smyrna, GA 30080

PATIENT INFORMATION

Date: ____________ Name: ____ Date of birth: _______________________ Sex: M / F
FIRST M.I. LAST

Social Security # _______-______-_________ Cell Phone: ________________________ Home Phone: __________________________

Work/Daytime Phone: ________________________________ Email: ____

Home Address: ____
STREET CITY STATE ZIP

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Unknown

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown **Primary Language:** ______________________________

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

IF PATIENT IS A MINOR PLEASE PROVIDE FINANCIALLY RESPONSIBLE PARTY INFORMATION BELOW:

Name of financially responsible party: _______________________________________ Social Security # _______-_______- _________
FIRST M.I. LAST

Date of birth: _______________ Relationship to patient: ❑ Parent ❑ Legal Guardian ❑ Other _______________________________

Address (if different from patient): ____
STREET CITY STATE ZIP

Cell Phone: ________________________ Home Phone: ______________________ Work Phone: _____________________________

INSURANCE INFORMATION

Insurance Company: _______________________________ ID # __________________________________ Co-pay amount: $ ______

Type: ❑ HMO ❑ POS ❑ PPO ❑ Medicare ❑ Other ____

Insurance Claims Address: ____
(usually on back of insurance card) STREET CITY STATE ZIP

Name of policy holder: ____ Policy holder's Social Security # _______-_____-_______
FIRST M.I. LAST

D.O.B. of policy holder: _______________ Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _________________

Address of policy holder (if different from patient): ____
STREET CITY STATE ZIP

Cell Phone: _____________________ Home Phone: ___________________ Work Phone: ______________________________

Policy Holder's Employer: _______________________________________ Occupation: _____________________________________

Secondary Insurance Company (If applicable): ____

EMERGENCY CONTACT

Emergency Contact Name: ____ Relationship: ___________________________________

Primary Phone: _______________________________ ❑ Cell ❑ Home ❑ Work

Secondary Phone: ____________________________ ❑ Cell ❑ Home ❑ Work Other info: ______________________________

SMYRNA FAMILY
MEDICINE

PATIENT AGREEMENT & CONSENT

1. Financial Agreement

I hereby assume full responsibility for ail charges incurred for professional services rendered by providers/physicians, unless the services are deemed "paid in full" as a result of contractual agreement between Smyrna Family Medicine office and my insurer. There may be a $35 No Show fee charged for appointments not cancelled within 24 hours. If you have paperwork to be filled out, a charge of $25 per page for the first 2 pages will apply and $80 for 3+ pages will apply. The charges will be due up-front prior to being seen by the provider. If you do not have insurance, payment will be collected prior to being seen by the provider. If you have additional balance afterwards then it will be collected after the visit. If your balance is less than the final amount, then you will be refunded the difference.

2. Authorization for release of information

I hereby authorize Smyrna Family Medicine to release any medical, psychiatric, infectious disease (including AIDS confidential information), drugs and/or alcohol related information to my referring provider/physician or any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this information is valid until such time as all my medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

3. Group & Individual Insurance, assignment of benefits

I authorize my health insurance benefit to pay directly to Smyrna Family Medicine, the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Smyrna Family Medicine for charges not covered by this agreement.

4. Medicare claim authorization and payment request

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

5. Consent of Treatment

I authorize request Smyrna Family Medicine to provide medical examinations, treatment, and/or diagnostic procedures, (including: venipuncture, urinalysis, glucose testing, oximetry, hemoglobin testing, injections) which now or during the course of my care as a patient are advisable. The frequency and type of treatments/ procedures will be decided between the provider/ physician and myself. I understand that the purpose of these treatments/ procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from these treatments/procedures, but there is no guarantee that this will occur.

6. Prescription Drug History Consent

In order to give you the highest quality of medical care, we need accurate information regarding your prescription medications. Therefore, I grant Smyrna Family Medicine permission to view my prescription history from my current or previous pharmacies.

7. Notice of Physician Assistant's Services

The physicians of this office employ the service of a Physician's Assistant, Michael E. Allen. Michael Allen is licensed in the State of Georgia to treat patients, order medications, and order other diagnostic testing under the supervision of the doctors of Smyrna Family Medicine. This waiver gives you permission to see the Physician's Assistant unless otherwise specified at the time you make your appointment. We will honor your request for the practitioner of your choice, unless in verifiable emergencies.

______________________________ SIGNATURE OF PATIENT OR GUARDIAN

______________________________ DATE

______________________________ RELATIONSHIP TO PATIENT (IF NOT PATIENT)

SMYRNA FAMILY
MEDICINE

PATIENT CONFIDENTIALITY & HIPPA ACKNOWLEDGEMENT

Patient Name: ____ Date of birth: ______________________
FIRST M.I. LAST

Patient confidentiality is a top priority at Smyrna Family Medicine. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I am unable to be reached, Smyrna Family Medicine may leave test results or other pertinent information with the following people:

Name		Relationship	Phone	
____________ (FIRST NAME)	____________ (LAST NAME)	/ ____________	/ ____________	❑ Cell ❑ Home ❑ Work ❑ Other
____________ (FIRST NAME)	____________ (LAST NAME)	/ ____________	/ ____________	❑ Cell ❑ Home ❑ Work ❑ Other
____________ (FIRST NAME)	____________ (LAST NAME)	/ ____________	/ ____________	❑ Cell ❑ Home ❑ Work ❑ Other
____________ (FIRST NAME)	____________ (LAST NAME)	/ ____________	/ ____________	❑ Cell ❑ Home ❑ Work ❑ Other

MESSAGES

May leave messages on voicemail/answering machine at: (check all that apply) ❑ home ❑ cell ❑ work phone

Other (Describe) ____

(Initials) __________ In the event I am unable to be reached, Smyrna Family Medicine may **NOT** leave tests results or any other information with anyone but myself.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Smyrna Family Medicine.

Acknowledgment of Receipt of HIPPA Notice of Patient Privacy Practices

By signing this Written Acknowledgment of receipt of Smyrna Family Medicine Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of Smyrna Family Medicine Notice of Patient Privacy Practices.

______________________________ PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

______________ DATE

______________________________ PATIENT OR LEGAL REPRESENTATIVE PRINTED NAME

❑ Acknowledgment NOT obtained because:

❑ Patient or Legal Representative declined Notice of Patient Privacy Practices

❑ Other (Briefly describe) ____

______________________________ SIGNATURE OF EMPLOYEE

______________ DATE

______________________________ PRINTED NAME OF EMPLOYEE

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SMYRNA FAMILY MEDICINE

David N. Kim, M.D.
Michael E. Allen, P.A.

3903 S. Cobb Dr. • Suite 200 • Smyrna, GA 30080 • 770-435-3214 (phone) • 770-437-6911 (fax)

Authorization for Release of Medical Information

Date: ____________ Patient Name: ____ Date of birth: ____________
FIRST M.I. LAST

Home Phone: ______________________________ Daytime Phone: ______________________________

Home Address: ____
STREET CITY STATE ZIP

I authorize Smyrna Family Medicine to:

❑ obtain information from:
❑ release information to:

Name of provider/facility: ______________________________ Phone: ______________________

Address: ____
STREET CITY STATE ZIP

Fax number: ______________________________

Specific description of information to be released:

❑ Complete Medical Records ❑ Progress Notes ❑ Labs Reports ❑ Radiology/Xray Reports

I authorize the release of records that my include diagnosis and treatment of HIV, alcohol & drug usage and/or mental health records). I understand that I may cancel this authorization at any time by submitting a written request to Smyrna Family Medicine except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.

______________________________ ____________________
SIGNATURE OF PATIENT OR GUARDIAN DATE

____
RELATIONSHIP TO PATIENT (IF NOT PATIENT)

Releasing provider or facility: Please return this form to

Smyrna Family Medicine
3903 S. Cobb Dr., Suite 200 • Smyrna, GA 30080

or fax to (770) 437-6911

SMYRNA FAMILY MEDICINE

Patient Name: ______________________________ Date: ______________________

NEW PATIENT INTAKE

Welcome to Smyrna Family Medicine. Please take this time to answer some questions about your health and medical history (front & back pages) to help us get to know you. Hand this to the nurse when she calls you back.

PRIOR AND CURRENT MEDICAL ISSUES:

PAST SURGERIES/PROCEDURES AND YEAR:

FAMILY MEDICAL HISTORY: *First-degree relatives only.*

MEDICATIONS—DOSES & HOW MANY TIMES YOU TAKE IT:

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DRUG ALLERGIES: *Name of drug(s) and what happens when you take it?*

PHARMACY: *Name of your pharmacy, phone and address:*

HEALTH MAINTENANCE:

When was your last tetanus immunization? _______________

When was your last yearly physical? ________________

SOCIAL HISTORY:

Occupation:

Do you smoke? If yes, how much?

Do you drink alcohol? How much & how often?

Are you married/single/divorced?

Children & ages:

Hobbies:

Do you exercise? What activity & how often?

CHIEF COMPLAINT:

What is the main reason you want to see the physician today?

ONLINE ACCESS TO YOUR LAB RESULTS AND HEALTH RECORDS:

If you would like to receive your tests results online as well as having secure access to your medical health record online, please provide your email address.

Email: ____

Thank you for taking the time to fill out this form!