Athens General and Colorectal Surgeons
740 Prince Avenue, Building 2
Athens, GA 30606
Phone: (706) 548-5488 Fax: (706) 548-0016

Please Fill Out Completely:

Patient's Last Name	First Name	MI

Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other	Language

Address (Street, Route, Apt. No., etc.)	City	State	Zip Code

Home Phone	Cell Number	Cell phone carrier (ex. Verizon)

Email Address	Best way to contact (Circle one): Home Phone Cell Phone Email Letter

Employed by				
Business Phone	Employer's Address	City	State	Zip Code

Person responsible for payment	Relationship to pt	Address	Phone Number

Insurance Policy Holder Name	DOB	Address	Policy holder SSN

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Address	City	State	Zip Code

Home Phone	Social Security	Date of Birth	Relationship to Patient

Employed by	Business Phone

Employer's Address	City	State	Zip Code

Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)	Daytime Phone

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____

_____

PHYSICIAN INFORMATION
Primary Care Physician _____

Address _____ Phone _____

Referring Physician (If different from Primary Care Physician) _____

Address _____ Phone _____

INSURANCE INFORMATION **(Please provide your insurance card(s) at the time of visit)**

_____ _____
Patient or Guardian Signature Date

ATHENS GENERAL AND COLORECTAL SURGEONS
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT
I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT
I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS
In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. 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.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Patient or Guardian Signature	Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Athens General and Colorectal Surgeons owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _____

_____

_____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

_____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for Athens General and Colorectal Surgeons and St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

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Authorization for Release of Medical Information

Patient: _____ Date of Birth: _____
(First) (Last)
I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

☐ Complete Health Record (or check for certain sections)

☐ ER Record	☐ Office Notes	☐ Echocardiogram Results
☐ History and Physical	☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)	☐ Nuclear Stress Test Results
☐ Discharge Summary		☐ CT Scan Results
☐ Consultation Report	☐ EKG	☐ Carotid-Vascular Study Results
☐ Operative Report	☐ Chest X-Ray Report	☐ Other as Specified_____
☐ Nursing Documentation	☐ Exercise Stress Test Results _____	

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

_____ Date: _____/_____/_____
Patient Signature

_____ Date: _____/_____/_____
Printed Name of Legal Representative

If signed by Legal Representative please provide the following:
Relationship to patient: _____
Authority to sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney for Healthcare
☐ Other, Please describe: _____

Records may be faxed and/or mailed to the fax number and the address provided above.

Athens General and Colorectal Surgeons
St. Mary's Medical Group

Medical History

Patient Name: _____ Date of Birth: _____

Chief Complaint: _____

Patient History (check all that apply):
☐ Lung Disease ☐ Stroke ☐ High Blood Pressure ☐ Anemia ☐ Liver Disease

☐ Diabetes ☐ Blood Clots ☐ Thyroid Disorder ☐ Heart Disease

☐ Cancer – Please specify: _____ ☐ Colorectal Cancer

☐ Other Significant History: _____

Date of last: Mammogram _____Colonoscopy _____Pneumovax _____

Past Surgeries (check all that apply):
☐ Breast Biopsy R or L ☐ Colonoscopy – Date and Results: _____

☐ Mastectomy R or L ☐ Hysterectomy ☐ Tonsillectomy ☐ Appendectomy

☐ Hernia Repair – Type: _____ ☐ Gallbladder

☐ Heart Surgery: _____ ☐ Other: _____

Review of Symptoms:

General
☐ Fever
☐ Weight gain
☐ Weight loss
☐ Fatigue

Gastrointestinal
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Changes in bowel habits
☐ Blood in stool
☐ Pencil thin stools
☐ Difficulty swallowing

Cardiovascular
☐ Chest Pain
☐ Irregular heartbeat
☐ Fainting

Respiratory
☐ Shortness of breath
☐ Cough
☐ Wheezing

Breast
☐ Breast pain
☐ Nipple discharge
☐ Breast lump – right
☐ Breast lump - left

Musculoskeletal
☐ Joint pain
☐ Muscle pain
☐ Joint swelling

Neurological
☐ Seizures
☐ Paralysis
☐ Frequent Headaches

Hematology
☐ Swelling of lymph nodes
☐ Easy to bruise
☐ Easy to bleed

Genitourinary
☐ Difficulty urinating
☐ Urinating frequency
☐ Blood in Urine

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Patient Name: _____ Date of Birth: _____

Allergies:
☐ None
☐ Latex
☐ Medications: _____

☐ Other: _____

Social History:
Do you smoke? ☐ Yes ☐ No Cigars Cigarettes Snuff or Chewing Tobacco

How Long: _____ Have you ever smoked? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No Use illegal drugs? ☐ Yes ☐ No

If yes, what type: _____ How long/how much: _____

Medications/Over the counter/Supplements
Do you take blood thinners? ☐Yes ☐ No

If so, which one and what dosage: _____

Do you take aspirin daily? ☐Yes ☐No Do you take Metformin? ☐Yes ☐No

Do you take any prescribed medicine, over the counter, non prescribed or health supplements?
☐ Yes ☐No

If yes, please list:

Name of med/supplement	Dosage	Frequency

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Patient name: _____ Date of Birth: _____

Family History (check all that apply):

Anemia: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Arthritis: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Cancer (list type): ☐Father _____ ☐ Mother _____

☐Father's Parents _____ ☐Mother's Parents _____

☐Sibling _____ ☐Children _____

Colon Polyps: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Diabetes: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Epilepsy: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Glaucoma: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Heart Disease: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Hypertension: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Kidney Disease: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Liver Disease: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Stroke: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Thyroid Disorder: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Stomach Ulcer: ☐Father ☐ Mother ☐Father's Parents ☐Mother's Parents ☐Sibling ☐Children

Other (please list): ☐Father _____ ☐ Mother _____

☐Father's Parents _____ ☐Mother's Parents _____

☐Sibling _____ ☐Children _____

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eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Athens General and Colorectal Surgeons may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____	_____
Patient Signature (or legal guardian)	Print Patients Name
_____	_____
Primary Pharmacy Name	Pharmacy Street and City
_____	_____
Secondary Pharmacy if applicable	Pharmacy Street and City
_____	
Date	