Cherokee Internal Medicine, P.C.

New Patient Intake Forms

PATIENT INFORMATION Today's Date: ________________

Last Name: ______________________________ First Name: _____________________________ M.I.: _______________

Address: ____ Apt. # _____________

City: ____ State: ________________ Zip: _____________

Home Phone: Cell Phone: Work Phone: Ext. _____

Email Address: ____

Date of Birth: _______________ Sex: M ____ F ____ Marital Status: S M D W

Race: American Indian/Alaska Native, Asian, Native Hawaiian, Black or African American, White, Hispanic, Pacific Islander, Other Race, Unreported/Refused to Report

How did you hear about the practice? ____

Emergency Contact Information:

Name: ____ Relation: ____________________________

Phone: ___________________________________ Work Phone: _________________________________

Do we have permission to discuss medical information with the person above? YES NO

Employer Information:

Employer Name: __________________________________ Occupation: ________________________________

Insurance Information:

Insurance Name & Address: ____

Name of Insured: ____ Relation: ____________________________

D.O.B. _______________________ ID/Contract # ____________________________ Group # _______________

Preferred Pharmacy:

Name: __________________________________ Location: _________________________

Phone: ____ Fax:____

Mail Order Pharmacy: ____

I hereby grant permission to Cherokee Internal Medicine to view my prescription history from external sources.

____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

NAME: ___________________________________

MEDICATIONS: List prescription medications being taken regularly including dosage:

NAME	DOSAGE	FREQUENCY

NON-PRESCRIPTION MEDICATIONS: List all non-prescription drugs including dosages and frequency of usage.

____

____

____

ALLERGIES: List all allergies to medications, immunizations, foods, etc.

MEDICATION	REACTION

NO KNOWN DRUG ALLERGIES: YES NO

PERSONAL HABITS: Circle the answer

Do you exercise regularly? YES NO Times per week __________ Type ___________________________

Do you chew tobacco or use tobacco in other forms? YES NO Packs per week _____ No. of years ____

Do you smoke tobacco? Never Current Smoker Former Smoker

Current smoker: How many packs per day? How many years?

Former Smoker: When did you start smoking? When did you quit smoking?

Do you vape? YES NO

Are you exposed to second-hand smoke? YES NO

Do you drink alcohol? YES NO Drinks per week?

Do you use illicit drugs? YES NO

Do you feel you have a dependency on any prescription drugs? YES NO

Advance Directive

(If yes, please bring a copy to your appointment)

Do you have a living will? YES NO

Do you have a Power of Attorney? YES NO

NAME: ______________________________________

PAST MEDICAL HISTORY: (circle all that apply)

Alcohol Dependency
Alzheimer's/Dementia
Anemia
Anxiety
Arthritis
Asthma
Back Trouble
Bipolar Disorder Bleeding
Disorder Blood Clots/
Phlebitis Bone Disorder
Breast Lump
Cancer: ___________
Cardiac Arrhythmia/A-Fib
Cataracts

Chronic Kidney Disease
Colitis (Ulcerative/Crohn's)
Colon Polyp
COPD
Depression
Diabetes Type 1
Diabetes Type 2
Diverticulitis
Eating Disorder
Epilepsy/Seizures
Glaucoma
Gout
Hay Fever/Sinus Disease
Heart Attack
Heart Failure

Heart Murmur
Hemorrhoid Hepatitis/
Liver Disease Hernia
High Blood Pressure
High Cholesterol
HIV Positive
Irritable bowel
syndrome (IBS)
Jaundice
Kidney Stone Macular
Degeneration
Migraine Headaches
Mononucleosis
Multiple Sclerosis

Osteoporosis
Pacemaker
Parkinson's Pneumonia
Prostate Problems
Rheumatic Fever
Sexually Transmitted
Disease Skin Disorder
Sleep Disorder Thyroid
Problems Tremors
Tuberculosis
Ulcers
Recurrent UTI (bladder/
kidney infection)

HOSPITALIZATIONS/SURGERIES:

List all surgeries and hospitalizations:
____
____
____

Indicate any major childhood illnesses:
____
____
____

Dates of Preventative Screenings/Vaccines: (mm/dd/yyy)

Bone Density Scan ________________________
Colonoscopy ________________________
Mammogram ________________________
EKG ________________________
Cardiac Stress Test ________________________
Eye Exam ________________________
Hearing Test ________________________
Hepatitis C Screening ________________________
HIV Test ________________________
Diabetic Eye Exam ________________________

Prevnar13 or Prevnar20 Vaccine__________________
Pneumovax23 Vaccine _________________________
Tetanus Vaccine (Td/Tdap) ______________________
Shingles Vaccine _________________________
Hepatitis A Vaccine _________________________
Hepatitis B Vaccine _________________________
TB Skin Test _________________________
Flu Vaccine _________________________
COVID vaccine _________________________
BCG Vaccine ________________________

MEN ONLY:

Do you perform self-testicular exams? NO YES

Date of last prostate exam: _____________________

Difficulty Initiating Stream	NO	YES	Dribbling after urination	NO	YES	Hard Testicle	NO	YES
Hernia	NO	YES	Hypospadias	NO	YES	Lump in Groin	NO	YES
Penile Discharge	NO	YES	Rash or blister on penis	NO	YES	Scrotal Pain	NO	YES
Scrotal Swelling	NO	YES	Undescended testicle	NO	YES	Vasectomy	NO	YES

NAME: ____

WOMEN ONLY:

First day of last menstrual period: __________________ Date of last PAP smear: __________________________

Number of pregnancies: ___________ Number of living children: _________________

Birth Control Method: None Oral Birth Control Implant IUD Other: ___________________

Breast lumps NO YES

Breast Pain NO YES

Discharge from Breast NO YES

Painful Menses NO YES

Hot Flashes NO YES

Extreme Menstrual pain NO YES

Irregular Menses NO YES

Missed Periods NO YES

Painful Intercourse NO YES

Painful Menses NO YES

Vaginal Discharge/Itching NO YES

Heavy bleeding during menses NO YES

Vaginal Bleeding Between Periods NO YES

Are you pregnant now? NO YES

FAMILY MEDICAL HISTORY:

Relation	Age	Health	Age of death	Cause of death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Brother #1				
Brother #2				
Brother #3				
Sister #1				
Sister #2				
Sister #3				

Has your blood relative ever had any of the following?	
Disease	**Relationship to you**
Arthritis	
Asthma	
Cancer (location)	
Chemical dependency/ Mental Illness	
Diabetes	
Heart Disease/Stroke	
High Blood Pressure	
Tuberculosis	
Osteoporosis	
Thyroid	
Seizures/Migraines	
Anemia	

CHEROKEE INTERNAL MEDICINE, P.C.

INSURANCE DISCLAIMER/FINANCIAL POLICY/CONSENT FOR TREATMENT

- To assure that your insurance claims are processed correctly and in a timely manner, **please make sure you advise us of any changes to your insurance information <u>prior to being seen</u>.** Incorrect information will result in your claim being denied.
- I certify that the above information is correct and hereby authorize the release of medical information to my insurance company and/or to my referring physician.
- I assign Cherokee Internal Medicine, PC (Maho Akamatsu, MD and Courtney Maniatis, DO) any and all payments for services rendered to me (or my dependents).
- A copy of this authorization may be used in place of the original.
- Insurance will be filed if the physician is covered under my plan.
- ***It is my responsibility to obtain a referral/order if required. I understand that I will be responsible for all non-covered services, co-payments and deductibles.***
- **All fees which are your responsibility are due at the time of your appointment.** These include any co-payments, co-insurances, deductibles, or any other charges not covered by your insurance. Failure to pay the time of your appointment will result in an additional **$25.00 administrative service fee** to be added to your bill.
- **$50.00 Fee** will be charged when a patient fails to provide us with **at least 24 hour notice of cancellation**, or is a “No Show”.
- I agree to be evaluated and treated by one of the providers of CIM, P.C. I the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to CIM, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ___________________________________

Signature Date

CHEROKEE INTERNAL MEDICINE, P.C.

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Cherokee Internal Medicine, P.C., or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should 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.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the disclosure of your protected health information.

Cherokee Internal Medicine, P.C., may or may not agree to restrict the use or disclosure of your protected health information.

If Cherokee Internal Medicine, P.C., agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Cherokee Internal Medicine, P.C., Reserves the right to modify the privacy practices outlined in this notice.

I have reviewed this consent form and give my permission to Cherokee Internal Medicine, P.C. to use and disclose my health information in accordance with it.

____
Patient Name (Print)

____ __________________________
Signature of Patient Date

____ __________________________
Signature of Patient Representative Relationship to Patient

CHEROKEE INTERNAL MEDICINE, P.C.

Informed Financial Consent Policy
Effective October 1, 2011

<u>**Patient Cancellation and No Show Policy**</u>

In order to provide all our patients with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive at least 15 minutes early for your appointment.

If you need to reschedule or cancel an appointment, we require <u>***a minimum of 24 hour cancellation notice.***</u> Adequate notice allows us to offer the appointment to another patient who needs to see the physician. **Please remember that confirmation reminders from us are only a courtesy. Our failure to confirm your visit does not relieve you of your responsibility to cancel your appointment.**

To cancel or reschedule, please call our office at:
*****678-238-0301 option 1*****

$50.00 Fee will be charged when a patient fails to provide us with at least 24 hour notice of cancellation, or is a "No Show".

<u>**Late Policy**</u>

We have a 15 minute late policy. If you are 15 minutes late to your appointment, you will have to reschedule your appointment for a different day.

<u>**Failure to Pay at Time of Service**</u>

All fees which are your responsibility are due at the time of your appointment. These include any co-payments, co-insurance, deductibles, or any other charges not covered by your insurance. Failure to pay at the time of your appointment will result in an additional **$25.00 administrative service fee** to be added to your bill.

<u>**Fees for Forms**</u>

To offset the runaway costs of the extensive administrative functions required by our physicians and staff, we are obliged to charge for completion of the tasks listed below. Please refer to the fees indicated for applicable requests. <u>**No forms will be completed prior to the payment of fees.**</u>

$75.00 Fee or <u>Free if completed at the time of an Office Visit with Physician</u>:

- Nursing home entrance forms**,** Adoption forms**,** Disability forms**,** Assisted Living forms**,** FMLA

$40.00 Fee or <u>Free if completed at time of Office Visit with Physician</u>:

- School Physical Education forms, Pre-Operative Forms

Medical record requests are priced individually. Please call our Medical Records Department to determine your costs.

__________________________________ ______________________ _______________

Signature of Patient | Date of Birth | Date

CHEROKEE INTERNAL MEDICINE, P.C.

RECEIPT OF NOTICE PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________________, have read/received a copy of CHEROKEE INTERNAL MEDICINE, P.C.'s Notice of Privacy Practices.

____ __________________

Signature of Patient/Patient Representative Date

CHEROKEE INTERNAL MEDICINE, P.C.

1192 Buckhead Crossing, Suite C
Woodstock, GA 30189
678-238-0301

Release of HIPAA Information

Patient Name: ____

Address: ____

____

Home Number:_____________________ Cell:____________________ Work:______________________

Date of Birth:______________________________ Social Security:___________________________

Email Address:__________________________________

May we leave a detailed message on your voicemail? YES NO

To be HIPPA Compliant we must ask that you authorize anyone you would like us to speak to, if their names are not of this form they will be advised that *you* must call to obtain any medical information.

I authorize Cherokee Internal Medicine to speak with the following person/people in regard to my protected health and financial information:

Name (first and last):__________________________________ Relationship:____________________

Home Phone: ______________________ Cell Phone: __________________________

Name (first and last):__________________________________ Relationship:____________________

Home Phone: ______________________ Cell Phone: __________________________

Assignment of Benefits: In consideration of these medical services, I hereby assign, transfer and set over to Cherokee Internal Medicine all my rights, title and interest to medical reimbursement benefits under my insurance policy (s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to Cherokee Internal Medicine, with regard to my treatment and care with this practice.

Consent for treatment: I hereby acknowledge and understand that, in presenting myself for treatment and continuing medical care at Cherokee Internal Medicine, PC that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the provider (and/or designated assistant) and carried out by members of Cherokee Internal Medicine staff and personnel. Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

____ ________________________

Patient Signature Date