St. Joseph's | Candler
Medical Group

Patient Registration

PATIENT DEMOGRAPHICS

Last Name	First Name	M	Nickname

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Birthdate (MM/DD/YYYY)	Gender ☐ Male ☐ Female ☐ Transgender

Practice communication preference for Appts, Rx Notices, Test Results: ☐ Phone ☐ Text (SMS) ☐ Both	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number

Employer Name	Occupation/Job Title	☐ Full-time ☐ Part-time

Employer Address	City	State	Zip Code

GUARANTOR INFORMATION (only if different from patient)

Last Name	First Name	M	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number

EMERGENCY CONTACT

Relation ☐ Parent ☐ Grandparent ☐ Care Giver ☐ Sibling ☐ Child ☐ Other___________________	Last Name	First Name	M

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Policy ID Number #

Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________

Group Number #	Group Name

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Policy ID Number #

Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________

Group Number #	Group Name

ST. Joseph's/Candler
Medical Group

Primary Care Physician: ______________________________ **Date of Last Exam:** ______________________________

Rx HISTORY CONSENT and ADVANCE DIRECTIVE

Indicate whether you consent for your provider to view your Rx history from external sources.

☐ Yes ☐ No

Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.

Do you have an Advance Directive? ☐ Yes ☐ No

If NO, would you like more information? ☐ Yes ☐ No

PATIENT PORTAL INFORMATION

Enable Web Portal? ☐ Yes ☐ No

Email Address **(Required for Web Portal)**

ADDITIONAL INFORMATION

Race

☐ Asian ☐ Black
☐ Hispanic ☐ White
☐ Other______________________

Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino

Language

☐ English ☐ Spanish
☐ Sign Language (ASL)
☐ Other ______________________

INSURANCE PREFERRED LAB AND RADIOLOGY SERVICES

If the preferred facility is not designated by the patient, their tests will be sent to St. Joseph's/Candler facilities and the patient will be responsible for payment.

Laboratory

☐ St. Joseph's/Candler ☐ LabCorp ☐ Quest
☐ Other______________________

Radiology/X-ray

☐ St. Joseph's/Candler
☐ Other______________________

PHARMACY INFORMATION

Pharmacy Name (Primary)		Phone #	Fax #
Address	City	State	Zip Code

AUTHORIZATION TO TREAT

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of St. Joseph's/Candler Medical Group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

☐ Yes ☐ No Initial ______________

ASSIGNMENT OF BENEFITS

I authorize release of information and payment of medical benefits to St. Joseph's/Candler for any services furnished. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

☐ Yes ☐ No Initial ______________

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

______________________________ ______________________

Patient Signature OR Authorized Representative *Date*

____

Printed Name of Authorized Representative

St. Joseph's/Candler Medical Group

Authorization for Release of Information for Specific Purposes of **HIPAA DISCLOSURE**

I hereby authorize SJC Medical Group to release OR receive the following information from the health records of:
Patient
Name: ____SSN: ________________________DOB: __________________________

To be released to:

Name	Relationship	Date of Birth	Phone

INFORMATION TO BE RELEASED: **(Check All That Apply)**

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics
☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Records

FOR THE PURPOSE OF:

☐ Anything on behalf of patient

☐ Creating/Changing/Canceling appointments

☐ View or correct demographic information to include signing in on my behalf

☐ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.

☐ Picking up prescriptions/forms and or medications on my behalf.

☐ Speaking to SJC Medical Group staff regarding my PHI including but not limited to billing and insurance information on my behalf.

☐ Other: ____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ONE YEAR** from the date listed below.

_______________________________________ _______________________

Patient Signature *Date*

_______________________________________ _______________________

Patient's Guardian or Capacity *Date*

____

Relationship to Patient

St. Joseph's|Candler Medical Group

Office Policies

Appointments and No Show Policy

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No Show fee will be charged to your account. If you have 3 or more No Shows within a 12 month period you could be discharged from the practice.

Financial Policy

Due to changes in today's healthcare, your insurance may not always pay for all services. Please make sure you understand your insurance plan and the services that are covered.

- Your Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If your insurance card is not provided, your appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you, we file your insurance claims, therefore, it is your responsibility to provide our office with up-to-date billing information.
- Please understand that your insurance is a contract between you and your insurance company, and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider, you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
- It is understood that checks made payable to this office returned for insufficient funds, stop payments, or other reason for non- payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges may be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance upon request. Please notify the front desk staff if you would like
  more information about how to apply for financial assistance.

Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills and Samples

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail-away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail- away prescriptions to allow adequate time for paperwork to be processed.

Test Results

Laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your lab/imaging results and notify you via voice message, letter or electronically sent to your patient portal. If you have not heard from us within 7 days, please call our office.

Referrals

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization, you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

Medical Records

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

ACKNOWLEDEMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

_______________________________________ _______________________

Patient Signature OR Authorized Representative *Date*

____

Printed Name of Authorized Representative

St. Joseph's|Candler
Medical Group

Patient Medical History

Today's Date: ______________________

Last Name: ________________________________ First Name: ______________________________ Middle: ___________

Chief Complaint

What is the main reason for your visit today? *(Describe your problem in detail)* ____

____

History of Present Illness

Location of the problem: ______________________________ How long does the problem last? ________________________

When did you first notice the problem? ____

Is the problem constant or variable? Dull then sharp Very sharp then stops Constant

Is anything else occurring at the same time? ________Yes ________ No

If yes, please explain. ____

On a scale of 0-10, with 0 being the least painful and 10 being the most painful. Circle the number:

Less pain More pain

0 1 2 3 4 5 6 7 8 9 10

Medical History

- ❑ Arthritis
- ❑ Gall Bladder Disease
- ❑ Liver Problems
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Heart Disease/Heart Attack
- ❑ Thyroid Disease
- ❑ Reflux/Heart Burn
- ❑ Bleeding Disorder
- ❑ Stroke/Mini-stroke
- ❑ Lung Problems
- ❑ Kidney Problems
- ❑ Seizure Disorder
- ❑ High Blood Pressure
- ❑ Migraines
- ❑ Irregular Heart Beat
- ❑ Neck/Back Problem
- ❑ Diabetes
- ❑ Cancer: Organ ____________________

Procedure History

Surgery	Date (Year)	Surgery	Date (Year)
❑ Heart Bypass/Valve Replacement	_________	❑ Stomach Surgery	_________
❑ Hernia Repair	_________	❑ Appendix Removed	_________
❑ Gallbladder Removed	_________	❑ Back/Neck Surgery	_________
❑ Joint Replacement	_________	❑ Prostate Surgery	_________
❑ Bladder/Kidney Surgery	_________	❑ Tonsils Removed	_________
❑ Organ Transplant	_________	❑ Other ______________________________________	

Family History

Check all that apply:

Family Members	Status (Alive, Deceased, Unknown)	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Father										
Mother										
Son(s)										
Daughter(s)										
Brother(s)										
Sister(s)										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

How many of the following do you have?

Brothers _____________ Sisters _____________ Sons _____________ Daughters _____________

Social History

Tobacco Use

❑ Current smoker Date started? _ How often? ❑ Every day ❑ Some days

How many? ❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31+

How soon after you wake? ❑ Within 5min ❑ 6-30min ❑ 31-60min ❑ after 60min

Interested in quitting? ❑ Ready to quit ❑ Thinking ❑ Not ready

❑ Former smoker Date last smoked? _______________________

How long since last smoked? ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5+ years

What type? ❑ Cigarettes ❑ Cigars ❑ Smokeless ❑ Pipe ❑ Other

❑ Never a smoked

Alcohol Use

Did you have a drink in the past year? ❑ Yes ❑ No

How often? ❑ Monthly ❑ 2-4 times mth ❑ 2-3 time week ❑ 4 or more a week

How many drinks on a typical day? ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-9 ❑ 10+

How often you have 6 or more on occasion ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

Illicit Drug Use

Have you used drugs other than those for medical reasons in past year? ❑ Yes ❑ No

What type? ❑ Amphetamines ❑ Cocaine ❑ Ecstasy ❑ LSD ❑ Crack ❑ Meth
❑ Prescription Opiates ❑ Heroin ❑ Marijuana ❑ Suboxone ❑ PCP

Route? ❑ Injected ❑ Intranasal ❑ Smoked

Frequency? ❑ Daily ❑ Weekly ❑ Monthly

Are you in treatment? ❑ Yes ❑ No

Drug Allergies	
Name of Drug	What kind of reaction do you have?

Current Medications

Are you taking any medications? ❑ YES ❑ NO If yes, list all current medications below you are taking and bring your prescription bottles to your visit.

Medication	Dose	Frequency	Reason for Medication	Prescribing Physician

Review of Systems

Please check box next to symptoms you currently have:

Gastrointestinal

- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Burping
- ❑ Blood in stool
- ❑ Other

Cardiovascular

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Varicose veins
- ❑ Palpitations
- ❑ Swelling of extremities
- ❑ Other

Constitutional Symptoms

- ❑ Fever
- ❑ Chills
- ❑ Sweating
- ❑ Weight loss
- ❑ Weakness
- ❑ Other

Skin

- ❑ Skin rash
- ❑ Boils
- ❑ Persistent itch
- ❑ Change in fingernails
- ❑ Hair loss
- ❑ Other

Eyes

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Other

Musculoskeletal

- ❑ Joint pain
- ❑ Back pain
- ❑ Neck pain
- ❑ Other

Ear / Nose / Throat

- ❑ Ear pain
- ❑ Hard of hearing
- ❑ Sore throat
- ❑ Runny nose
- ❑ Other

Hematologic / Lymphatic

- ❑ Swollen glands
- ❑ Easy bruising
- ❑ Other

Neurological

- ❑ Tremors
- ❑ Dizzy spells
- ❑ Memory Problems
- ❑ Frequent Headaches
- ❑ Other

Respiratory

- ❑ Wheezing
- ❑ Frequent cough
- ❑ Sputum
- ❑ Other

Endocrine

- ❑ Excessive thirst
- ❑ Fatigue
- ❑ Other

Allergic / Immunologic

- ❑ Seasonal allergies
- ❑ Sneezing
- ❑ Watery/Itchy Eyes
- ❑ Other

Female Genitourinary

- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Pain on urination
- ❑ Vaginal discharge
- ❑ Urine leakage
- ❑ Lower abdominal pain
- ❑ Blood in urine
- ❑ Painful menstruation
- ❑ Other

Male Genitourinary

- ❑ Pain in the testicles
- ❑ Penile discharge
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Frequent urination
- ❑ Dribbling of urine
- ❑ Difficulty starting urine
- ❑ Other