PERSONAL CARE PHYSICIANS OF ATLANTA

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE

Our Notice of Privacy Practices provides information about how we may use and disclose protect health information about you. As provided in our notice, the terms of our notice may change in the future. The current notice will be posted in our office with the effective date in the upper right hand corner.

By signing below, you acknowledge that you are aware of our privacy policy and may receive a copy of our Notice of Privacy Practices if so desired.

Patient Name ____ Chart # ____________________

Patient/Responsible Party Signature____

Date ______________________________

Authorization for Release of Information and Payment of Benefits

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to Personal Care Physicians of Atlanta of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Personal Care Physicians of Atlanta by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Patient Name (please print) Date

Patient Signature Authorization

Please Note: Payment is expected in full at the time of medical care. If we are participating in your insurance plan we would appreciate your copay in cash. Thank you.

5673 PEACHTREE DUNWOODY RD., SUITE 950
ATLANTA, GEORGIA 30342

MARC A. SELTMAN, M.D.
RICHARD D. KAPLAN, M.D.

TEL. 404-256-3135 • FAX 404-256-3137

CHART #

Patient Information

PLEASE PRINT CLEARLY

Please help us serve you better by taking a few minutes to provide the following information.

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER

STREET ADDRESS	BIRTHDATE	AGE	SEX F M

CITY	STATE	ZIP CODE	HOME PHONE ( )
BEST CONTACT NUMBER ☐ HOME ☐ WORK ☐ CELL	BEST TIME OF DAY ☐ AM ☐ PM	OKAY TO LEAVE MESSAGE ☐ YES ☐ NO	CELL PHONE ( )

EMPLOYER NAME	OCCUPATION	BUSINESS PHONE ( )

STREET ADDRESS	CITY	STATE/ZIP CODE

MARITAL STATUS ☐ S-SINGLE ☐ M-MARRIED ☐ D-DIVORCED ☐ W-WIDOWED ☐ S-SEPARATED	EMAIL

SPOUSE (PARENT/GUARDIAN)	D.O.B.	SPOUSE, PARENT/GUARDIAN WORK PHONE ( )

EMERGENCY CONTACT	RELATIONSHIP	PHONE ( )

REFERRED BY (FULL NAME) ☐ MEDICAL DOCTOR ☐ RELATIVE ☐ FRIEND ☐ INSURANCE	PHARMACY PHONE ( )

INSURANCE INFORMATION: CO-PAY AMT.: ____________________ DED. AMT.: ____________________

PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
INSURED	INSURED
RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

YOU MUST SUPPLY COPY OF INSURANCE CARD!!!

____

Please Sign Here Date

PAGE #

CHART #

HISTORY & PHYSICAL

Formedic

DATE

NAME | M F | MARITAL STATUS S M W D SEP | DATE OF BIRTH

ADDRESS | PHONE (H) | (O)

OCCUPATION/ EMPLOYER | INSURANCE

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Hay fever	11) Arthritis	16) Cancer
2) Migraine	7) Asthma	12) Heart disease	17) Restless leg syndrome
3) Glaucoma	8) Anemia	13) Stroke	18) Depression
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental illness

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

SUPPLEMENTS

VACCINE	YEAR OF LAST	VACCINE	YEAR OF LAST
Tetanus / Td		MMR Measles Mumps Rubella	
Influenza (flu)			
Pneumonia		Meningitis	
Hepatitis A		Chicken pox	
Hepatitis B		HPV	
Whooping C		Shingles	

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

☐ Hearing problems ☐ Ringing in ear
☐ Dizzy spells ☐ Fainting spells
☐ Vision problems ☐ Eye pain
Date of last eye exam
☐ Nose bleeds ☐ Sinus trouble
☐ Sore throats - *frequent*
☐ Hoarseness - *prolonged*
☐ Hayfever / Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
Date of last TB test
☐ Shortness of breath:
☐ on exertion ☐ lying flat
☐ in the past week
☐ affects work lifestyle
☐ Chest pain ☐ High blood pressure
Date of last cholesterol test
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain ☐ Cold numb feet
☐ Varicose veins / Phlebitis
☐ Appetite ☐ Difficulty swallowing
☐ loss ☐ gain

☐ Heartburn ☐ Peptic ulcer
☐ Aspirin - arthritis - pain pills
☐ Nausea / vomiting ☐ Gallbladder dis
☐ Jaundice / Hepatitis
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Crohn's / Colitis
☐ Bloody or tarry stools
☐ Test for blood in stool
☐ Hemorrhoids ☐ Hernia
Urination - Overactive bladder
☐ Overnight > than twice
☐ More than 8 times / 24 hrs.
☐ Urgency to urinate ☐ with leakage
☐ Decrease in force/flow ☐ Painful
☐ Stress incontinence-urine leakage with exercise / movement
☐ Blood in urine ☐ Kidney stones
☐ Urine infections ☐ Prostate prob
☐ Bed wetting
☐ Weight-loss ☐ gain
☐ Anemia ☐ Bruise easily
☐ Cancer ☐ Fatigue / loss of energy
☐ Diabetes ☐ Thyroid disease

☐ Arthritis / Rheumatism ☐ Back pain
☐ Bone fracture / joint injury
☐ Osteoporosis ☐ Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Excessive sweating
☐ Seizures ☐ Stroke
☐ Tremor/hands ☐ Numbness
☐ Headaches ☐ Memory loss
☐ Depression ☐ Confusion
☐ Decreased work performance
☐ Sleep problems
for how long ___ how often ___
sleeping - ☐ too little ☐ too much
waking refreshed ☐ yes ☐ no
☐ Legs keep you up at night
☐ Concentration problems
☐ Difficulty with unfamiliar tasks
☐ Thoughts of death ☐ suicide
☐ Anxiety ☐ Mood swings ☐ Phobias
☐ Mental illness
☐ Sexual problems / enjoyment
☐ Rheumatic fever ☐ Measles
☐ Chicken pox ☐ Polio ☐ Mumps

☐ Tuberculosis ☐ German measles
☐ Herpes ☐ Aids / HIV
☐ Sexually transmitted diseases - # of encounters ___
☐ Alcohol ___ oz. per week
☐ Coffee / Tea ___ cups per day
☐ Smoking- cig/day ___ # years
year quit ___
☐ Exercise
☐ Street drugs
☐ Travel abroad

FEMALES - *Please complete*
Menstrual flow:
☐ Reg. ☐ Irreg. ☐ Pain / Cramps
Days of flow ___ Length of cycle ___
Date -1st day of last period
☐ Pain / Bleeding during or after sex
Number of:
Pregnancies ___ Abortions ___
Miscarriages ___ Live births ___
Birth control method
☐ Flushing / Menopause
Date of last PAP test
☐ Normal ☐ Abnormal
Date of last mammogram
☐ Normal ☐ Abnormal

SYNOPSIS