SAVANNAH MEDICAL GROUP

12345 Mercy Blvd, Savannah, GA 31419

Please fill out the following information and bring this record to your appointment. It will help your physician know not only abut your health but also about your family and relatives.

Date: ________________ Date of Birth: ________________ Email: ________________________________

Full Name: ____ Telephone Number: ____________________

Street Address: ____ City/State/Zip: _________________________

Occupation: ____ How Long: _________________________

Place of Birth: ____ Religion: ___________________________

Race/Nationality of Parents: ______________________________ Level of Education Completed: ____________

Marital Status: M__ D__ S__ W__ Have you ever been divorced? __________

Present Marriage – Years: ____________ Are you currently separated? ____________

Were you referred?: ____________ If so, by whom: ____

Are any of your relatives registered patients here?: Yes: ____ No: ____

If yes, Name(s)/Relationship: ____

List other physicians you've seen in the past 3 years:

Physician Name: _________________________ Address: ____

Physician Name: _________________________ Address: ____

Physician Name: _________________________ Address: ____

Physician Name: _________________________ Address: ____

PAST MEDICAL HISTORY

Please circle illnesses or conditions which you have had or currently have:

Diabetes	**Pneumonia**	**Kidney Disease**	**Cancer**	**Heart trouble**
Tuberculosis	**Rheumatic Fever**	**Jaundice**	**Asthma**	**Vein Problems**
Glaucoma	**Syphilis**	**Fainting**	**Gonorrhea**	**Bleeding Tendencies**
Arthritis	**High Blood Pressure**	**Back Pain**	**Stroke**	**Nervous Disorder**

Please list any serious injuries or broken bones you have had:

____

____

Operations or procedures: ____ Date: ______________

____

Please list any medications you are currently taking or have recently taken:

____

____

____

Have you received a blood transfusion? ________________________ Date: ________________

Have you had allergy or sensitivity to any medications or other substances? _________________________

If yes, please describe: ____

FAMILY MEDICAL HISTORY

	Living	Age/Age at Death	Present Health or Cause of Death
Father:	Yes: __ No: __	_________	____________________________________
Mother:	Yes: __ No: __	_________	____________________________________

Spouse: Yes: __ No: __ __________ ____

Brother: Yes: __ No: __ __________ ____

Sister: Yes: __ No: __ __________ ____

Child One: Yes: __ No: __ __________ ____

Child Two: Yes: __ No: __ __________ ____

Child Three: Yes: __ No: __ __________ ____

Please circle illnesses which have occurred in any of your blood relatives:

Diabetes	**Stroke**	**Kidney Disease**	**Allergy**
Cancer	**Arthritis**	**Heart Disease**	**High Blood Pressure**
Tuberculosis	**Back Problems**	**Nervous Disorder**	**Bleeding Tendencies**

Please list any other serious illnesses in your blood relatives:

____

____

____

SOCIAL HISTORY

Do you use tobacco now? ___________ In the past? ___________ How long did you use it? _____________

Type of tobacco used and daily amount: ____

Do you use alcoholic beverages? __________ In the past? ___________ How long have you use it? __________

Type of alcohol used and weekly amount: ____

Where and when have you lived or traveled outside the United States and Canada?

____

____

Please circle the appropriate response:

GENERALIZED COMPARTMENT

Yes No Do you ever experience fever or chills?

Yes No Have you had a fever in the past month?

Yes No Have you had shaking chills in the past month?

Yes No Have you broken out in a sweat during the past month?

EYES, EARS, NOSE AND THROAT COMPARTMENT

Yes No Do you have trouble with your vision?

Yes No Has a doctor ever said you have glaucoma?

Yes No Do you regularly have difficulty with hearing?

Yes No Do you experience noises in the ears (i.e. ringing)?

Yes No Are you often lightheaded?

Yes No Do you often feel as if the room is spinning?

Yes No Do you often have colds?

Yes No Are you often bothered by sinus trouble?

Yes No Has your voice been persistently hoarse in the past year?

Yes No Do you frequently have a sore throat?

Yes No Have you had bleeding gums often in the past year?

CARDIOTHORACIC COMPARTMENT

Yes No Are you troubled with a cough almost every day?

Yes No Do you regularly cough up much phlegm or sputum?

Yes No Have you coughed up blood in the past year?

Yes No Have you had severe bronchitis in the past year?

Yes No Do you have frequent chest colds?

Yes No Have you had pneumonia in the past year?

Yes No Have you experienced asthma issues in the past year?

Yes No Are you unusually short of breath when walking or working?

Yes No Has a doctor ever said you have emphysema of the lungs?

Yes No Are you often troubled with chest pain?

Yes No Do you often feel chest pressure or tightness when excited?

Yes No Does your heart often thump or race?

Yes No Are your feet and legs unusually swollen by the end of the day?

Yes No Has a doctor ever said you have/had heart trouble?

Yes No Has a doctor ever said you have high blood pressure?

GASTROINTESTINAL COMPARTMENT

Yes No Are you often nauseated?

Yes No Do you often vomit?

Yes No Are you often constipated?

Yes No Do you often have diarrhea?

Yes No Do you have black, bloody, or yellow bowel movements?

Yes No Do you feel week?

Yes No Have you lost weight recently?

Yes No Have you ever had yellow jaundice?

Yes No Have you had any blows or injuries to your abdomen?

Yes No Do you have a poor appetite?

Yes No Do you have heartburn?

Yes No Do you have indigestion?

Yes No Do you have pain in your abdomen?

Yes No Are you often troubled by excessive gas or bloating?

Yes No Are you often bothered by itching around the rectum?

Yes No Has a doctor ever said you have/had a stomach or duodenal ulcer?

Yes No Has a doctor ever said you have/had gallbladder trouble?

Yes No Have you bled from your rectum during the past year?

Yes No Do you often have trouble swallowing foods?

Yes No Do you often have trouble swallowing liquids?

GENITOURINARY COMPARTMENT

Yes No Do you regularly get up more than once from sleep to urinate?

Yes No Are you often bothered by burning or pain when urinating?

Yes No Have you had pus or blood in the urine during the past year?

Yes No Do you often have trouble starting urination?

Yes No Do you often have trouble emptying your bladder completely?

Yes No Have you ever passed a kidney stone in your urine?

Yes No Have you been treated for a urinary infection in the past year?

PSYCHIATRIC COMPARTMENT

Yes No Are you tired most of the time?

Yes No Do you frequently have trouble sleeping (insomnia)?

Yes No Do you frequently feel nervous or upset?

Yes No Have you ever had a nervous breakdown?

Yes No Do you often feel discouraged or depressed?

Yes No Have you ever visited a minister, marriage counselor, or social worker to discuss personal problems?

Yes No Have you ever visited a psychologist or psychiatrist?

Yes No Do you have difficulties in your sex life?

Yes No Do you often drink more alcohol than is good for you?

NEUROLOGICAL COMPARTMENT

Yes No Do you often experience bad headaches?

Yes No Are you subject to fainting or blackout spells?

Yes No Have you ever had a convulsion or seizure?

Yes No Have you been paralyzed?

Yes No Do you often have numbness in your feet?

Yes No Have you notices local or generalized weakness?

MUSCULOSKELETAL COMPARTMENT

Yes No Are you bothered by back pain?

Yes No Do you have stiffness in the back or any other joint(s)?

Yes No Are you bothered by rheumatism or arthritis?

Yes No Has a doctor ever said you have gout?

DERMATOLOGICAL COMPARTMENT

Yes No Are you bothered often with a skin rash?

Yes No Are you bothered often with a skin itching?

Yes No Do you have other skin problems?

HEMATOLOGICAL COMPARTMENT

Yes No Do you often have large bruises on your skin?

Yes No Do you bleed or hemorrhage excessively?

Yes No Have you been treated for anemia in the past year?

ENDOCRINOLOGICAL COMPARTMENT

Yes No Do you often feel cold in a room that is comfortable for others?

Yes No Do you often feel warm in a room that is comfortable for others?

Yes No Do you sweat or perspire excessively?

Yes No Has a doctor ever said you had thyroid trouble?

Yes No Has your weight increased more than 10 pounds in the past year?

Yes No Has a doctor ever said you have diabetes?

Yes No Has a doctor ever said you have hypoglycemia (low blood sugar)?

Yes No Have you ever taken cortisone type drugs?

GYNECOLOGICAL COMPARTMENT (females only)

Yes No Do you have a lump in your breast?

Yes No Have you ever had a discharge from your nipple(s)?

Yes No Have you taken oral contraceptives within the past year?

Yes No Are your menstrual periods heavy?

Yes No Have you had bleeding between menstrual periods within the past year?

Yes No Have you had a Pap test within the past year?

Last menstrual period (date) ________________

Menstrual periods are regular _____ irregular _____

Have your menstrual periods stopped? Yes _____ No _____

Number of pregnancies: _____ Number of miscarriages: _____

Your thoughts on your health status:

I was in my usual state of health until:

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Patient's Name: ______________________________ ___ Male ___ Female Marital Status: M S D W

Birth Date: _________________ Primary Phone #: ____________________________ Age: __________

Patient's Address: __________________________________ City, State: ______________ Zip Code: ________

Patient's Employer: _________________________ Occupation: _______________ Work Phone #: ____________

Employer's Address: _________________________________ City, State: _______________ Zip Code: _______

Spouse's Name: ______________________________ Birth Date: _____________ Phone #: _________________

Address (If different from patient): ______________________________ City, State: _____________ Zip Code: _______

Spouse's Employer: ________________________ Occupation: _______________ Work Phone #: ___________

Nearest Relative & Address: ____

Relationship: _________________________________ Phone #: ______________________________

Primary Insurance: ________________________________ Policy/ID #: __________________________________

Billing Address: _________________________________ City, State: _________________ Zip Code: ________

Full Name of Insured: ____ Birth Date: ______________________

Secondary Insurance: ________________________________ Policy/ID #: ________________________________

Billing Address: _________________________________ City, State: _________________ Zip Code: ________

Full Name of Insured: ____ Birth Date: ______________________

Tricare Benefit #: ___________________ SS#: _________________ Effective Date: ______________________

Rank: _________________ Spouse's Name: _____________________________________ Retired: ____________

Referred By: ____ Phone #: ___________________________

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QUESTIONS ABOUT YOUR INSURANCE

Is Dr. Northup a preferred provider for your insurance company? Yes ___ No ___

Do you have a yearly deductible? Yes ___ No ___

If yes, amount per year $ ______________________

Has your deductible been met? Yes ___ No ___

Do you have a co-pay for office visits? Yes ___ No ___

Does your insurance company cover office visits? Yes ___ No ___

Does your insurance company have a preferred laboratory for lab testing? Yes ___ No ___

If yes, who? ____

Does your insurance company have a preferred hospital? Yes ___ No ___

If yes, who? ____

Do you need a referral for mammograms, ultrasounds or any other radiological procedures? Yes ___ No ___

Providing our office with this information will prevent you from incurring unnecessary medical expenses.

Your signature below indicated that you have verified your insurance benefits and understand that you will be financially responsible for all non-covered and denied charges in addition to your normal percentage and/or co-pay.

Patient Signature: _______________________________________ Date: __________________

Patient Name Printed: ____________________________________

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

And

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

1) I authorize this office to release or resolve any information necessary to expedite insurance claims.
2) I authorize this office to bill my insurance company directly for their expenses.
3) I authorize payments directly to this physician for any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance company, I agree to endorse any payments I have received over to my physician for which these fees are payable.

FINANCIAL POLICY

We strongly feel that al patients deserve from us the very best medical care that we can provide. Further, we feel everyone benefits when definitive financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company; therefore, payment for treatment is your responsibility. Accordingly, we have prepared this material to acquaint you with our policy.

1) I understand it is my responsibility to obtain referrals from any primary physician or health plan prior to my appointment.
2) I understand I am directly and fully financially responsible to the physician(s) or physician assistant for charges not covered by my insurance.
3) I further understand that such payment is not contingent upon any settlement, judgment, or insurance payment by which I eventually recover said fee.
4) I understand if any insurance company fails to pay my balance in full within ninety (90) days, or there is no payment made within ninety (90) days, It is my responsibility to pay my doctor's bill directly.
5) I further understand and agree that I will be responsible for any and al costs of collections, including collection agency fees, filing fees and attorney fees.

Patient Signature: ____________________________________ Date: ________________

Patient Name Printed: _________________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/MEDICAL INFORMATION

I hereby authorize Savannah Medical Group to release/receive information from the medical records of:

Patient: ____________________________________ SS#: ____________________________________

Date of Birth: _________________________ Date of Service: ___________________________________

Release to/from: ____

Purpose or need for information: ____

____

I am aware of my specific waive and privilege regarding the following information which may or may not be considered in these records:

1) Communications between patient and psychiatrist.
2) Communications between patient and psychologist.
3) Medical information concerning alcohol and/or drug dependency.
4) Medical information concerning alcohol and/or drug abuse.
5) Medical information concerning mental retardation.
6) Medical information concerning acquired Immune Deficiency Syndrome.

This release is subject to revocation at any time.

Patient Signature: ____________________________________ Date: ________________

Patient Name Printed: _________________________________

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: ___________________________________ Date of Birth: ________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below. I authorize Savannah Medical Group to release my medical and/or billing information to the following individual(s):

1) Name: _______________________________________ Relation to Patient: ___________________
2) Name: _______________________________________ Relation to Patient: ___________________
3) Name: _______________________________________ Relation to Patient: ___________________

Patient information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above noted individual is no longer protected by federal or state law and may be subject to re-disclosure by the above noted individual. You have the right to revoke this consent in writing.

Patient Signature: ____________________________________ Date: _________________

Patient Name Printed: _________________________________

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PATIENT QUESTIONNAIRE

Patient Name: ___________________________________ Date: ________________________

1) How did you hear or read about Dr. Northup and our office?

2) On what date did you first call our office for an appointment?

3) Was the receptionist courteous and polite?

4) What was the nature of the problem that you discussed with the receptionist on that date?

5) Did the receptionist offer you an appointment within 2-3 days?

6) Do you know the name of the receptionist with whom you spoke? Did she identify herself by name?

7) If you were not offered an appointment within 2-3 days, how long were you asked to wait before you could receive and appointment?

8) If you were offered an appointment within 2-3 days, did you accept this offer?

9) What so you anticipate we will do at the time of your first visit?

10) Are you pleased with the way things have proceeded up to the present time? If you are, please tell the doctor.

Sincerely yours,

John D. Northup, M.D.