# Premium Life Medical Center Patient Intake Form

## Patient Demographic Information:

First Name: ______________________________

Last Name: ______________________________

Date of Birth: ______________________________

Sex (circle one): Male Female

Preferred Pronouns: ______________________________

Marital Status: ______________________________

Address: ______________________________

Email: ______________________________

Preferred Phone Number: ______________________________

## Emergency Contact:

Full Name: ______________________________

Relationship: ______________________________

Contact Number: ______________________________

## Health and Medical Information:

Primary Care Physician (if applicable): ______________________________

Primary Care Physician Contact Number: ______________________________

**Please list any medical conditions:**

**Please list any current medications:**

**Reason for today's visit?**

| |
|---|
| |

**For Women: Are you pregnant?**

**Yes** ☐

**No** ☐

***If Yes, for how long?**

## Insurance Information (If Applicable)

Insurance Carrier:

Insurance Plan:

Contact Number:

Policy Number:

Group Number:

Social Security Number:

## Employment Status

| ☐ Employed | ☐ Self Employed | ☐ Unemployed | ☐ Other: |
|---|---|---|---|

Occupation:

Industry:

Company Name:

Company Address:

City:

State:

Zip Code:

# Medical History

PREMIUM LIFE MEDICAL CENTER
639 Beaver Ruin Rd Suite “A” Lilburn Ga 30047
678-395-3443
premiumlifemedical@gmail.com

Full name:________________________________________ Date of birth:__________________ Date:__________________

Primary doctor:____________________________________________________________________________________________

Doctor who requested today’s visit: ___________________________________________________________________________

List current/previous doctors and their specialty:_________________________________________________________________

**ALLERGIES AND REACTIONS** **MEDICATIONS** (list dosage and how you take them, ___ including non-prescription, herbs, birth control)

______________________________ ______________________________________

______________________________ ______________________________________

______________________________ ______________________________________

**PAST MEDICAL ILLNESSES** (please check if you have had the following):

❑ Alcohol/Drug addiction ❑ Cancer (type): ❑ Gout ❑ Kidney stones ❑ Stroke
❑ Anemia ❑ Breast ❑ Ovarian ❑ Hay fever ❑ Liver disease ❑ Thyroid disease
❑ Aneurysm ❑ Colon ❑ Uterine ❑ heart disease ❑ Seizure ❑ Tuberculosis
❑ Anxiety disorder ❑ ____ ❑ Heart murmur ❑ Sexually transmitted ❑ (Positive) TB skin test
❑ Arthritis ❑ Crohn’s disease ❑ Hepatitis B or C disease (type): ❑ Ulcerative colitis
❑ Asthma ❑ COPD/Emphysema ❑ High cholesterol _______ ❑ Other:______
❑ Blood disorder ❑ Depression ❑ HIV ❑ Sickle cell disease _______
❑ Blood clot ❑ Diabetes ❑ Hypertension ❑ Sleep apnea _______
❑ Blood transfusion ❑ Glaucoma ❑ kidney disease ❑ Stomach ulcer _______

| **OPERATIONS** | **DATES** | **HOSPITALIZATIONS** | **DATES** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY HEALTH HISTORY** ❑ Adopted

| Family Members | Major Medical Problems | If Deceased, Causes | Age at Death |
|---|---|---|---|
| Maternal Grandmother | | | |
| Paternal Grandmother | | | |
| Maternal Grandfather | | | |

| Paternal Grandfather | | | | |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Brothers and Sisters | 1) ❑ M ❑ F | | | |
| | 2) ❑ M ❑ F | | | |
| | 3) ❑ M ❑ F | | | |
| Sons and Daughters | 1) ❑ M ❑ F | | | |
| | 2) ❑ M ❑ F | | | |
| | 3) ❑ M ❑ F | | | |



## SOCIAL HISTORY

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years?_____ Are you a former smoke? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit?_____
Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:_________

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who? Advanced Directive for Healthcare

## HEALTH MAINTENANCE

Last menstrual period:__________________ Last pap smear:__________________ Last mammogram:___________________

Last colonoscopy:_ Last prostate cancer screening:_ Last bone density scan:_ Immunizations: ❑ Pneumovax:_ ❑ Flu:_ ❑ Tetanus: __________ ❑ Hep A: _______ ❑ Hep B:

## REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

❑ Weight gain ❑ Persistent cough ❑ Blood in stool ❑ Headaches
❑ Weight loss ❑ Chest discomfort ❑ Difficulty urinating ❑ Memory loss
❑ Night sweats ❑ Palpitations ❑ Trouble holding urine ❑ Numbness/Tingling
❑ Weakness ❑ Fainting ❑ Frequency of urination ❑ Tremor
❑ Fatigue ❑ Change in exercise tolerance ❑ Penis discharge ❑ Uncontrollable mood swings
❑ Insomnia ❑ Difficulty swallowing ❑ Vaginal discharge/bleeding ❑ Anxiety
❑ Change in hearing ❑ Indigestion or heartburn ❑ Nipple discharge ❑ Depression
❑ Change in vision ❑ Nausea ❑ Breast pain ❑ Skin Rash
❑ Runny nose ❑ Vomiting ❑ Breast lump ❑ Back pain
❑ Nose bleed ❑ Constipation ❑ Pain with intercourse ❑ Leg pain
❑ Fever ❑ Diarrhea ❑ Feeling too hot ❑ Leg swelling
❑ Blood in sputum ❑ Change in bowel habit ❑ Feeling too cold ❑ Other:______
❑ Shortness of breath ❑ Blood in vomit ❑ Dizziness

__________________________ __________________________ ____________________
Patient/Designee signature Patient name (**PRINT**) Date

**Premium Life Medical Center**
*639 Beaver Ruin Rd Suite A*
*Lilburn, Ga 30047*
Phone: 678-395-3443
Fax: 770-837-2426

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Name:**______________________________________________________________
**Address:**____________________________________________________________
**Phone:**_____________________________ **Date of Birth:**___________________________

I hereby authorize this practice to make uses and disclosure of my protected Health Information (PHI) (information about me in my medical records and/or financial records) as required for relevant procedures, orders, and other communication purposes.

Patient Signature ______________________

Signature of Patient's Representative/Legal Gaurdian ______________________
Title or Relationship to Patient ______________________

Date ______________________

### *For clinic use*

I hereby authorize this practice to make uses and disclosure of my protected Health Information (PHI) (information about me in my medical records and/or financial records) as indicated below

***To release to: (Name and Address of Person or Agency holding the information)***

| Name: | | Phone: |
|---|---|---|
| Address: | | Fax: |
| City: | State: | Zip: |
| ***To obtain from: (Name and Address of Person or Agency Holding the information)*** | | |
| Name: | | Phone: |
| Address: | | Fax: |
| City: | State: | Zip: |
| Description of information to be disclosed: **MEDICAL RECORDS** | | |

All information I authorize to be released from this agency will be held strictly confidential. I understand that this authorization will remain in effect for:
Ninety (90) days, unless I specify and earlier expiration date here _________________

One (1) year from the date of signature date

X Patient Signature ______________________

Signature of Patient's Representative/Legal Gaurdian ______________________
Title or Relationship to Patient ______________________

X Date ______________________

Premium Life Medical Center

**I UNDERSTAND THE FOLLOWING:**

. I May revoke this authorization at any time by providing written notice to the practice.
. I may not be able to revoke this authorization if the practice has already take action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
. The practice will not condition treatment or payment based on my signing this authorization.
. I am signing this authorization freely.
. The information disclosed in this authorization may be subject to re-disclosure by the practice and no
longer protected by federal law.
. I acknowledge that I have had an opportunity to review the authorization and understand the intent and the use and have received a copy of the authorization.
. Upon taking possession of the medical records from Premium Life Medical Center I agree to release PLMC of all responsibility for the records and I will be liable if the records are lost, stolen, or left anywhere.

✕ Patient Signature _____________________

Signature of Patient’s Representative/Legal Gaurdian _____________________
Title or Relationship to Patient _____________________

✕ Date _____________________

**Premium Life Medical Center**
*639 Beaver Ruin Rd Suite A*
*Lilburn, Ga 30047*
Phone: 678-395-3443
Fax: 770-837-2426

# AUTHORIZATION FOR MINORS

**Patient Name:** ____________________________________________________________________
**Address:** ____________________________________________________________
**Phone:** ____________________________ **Date of Birth:** ______________________
**Legal Gaurdian:** _________________________________________________________
**Emergency Contact (Name & Phone):** _______________________________________
**Is joint custody shared?** ☐ **Yes** ☐ **No**

**Please list the following people who may bring in and/or discuss your child's healthcare with Premium Life Medical Center:**

**Name:** _________________ **Relationship:** __________________ **Phone:** ______________

**Name:** _________________ **Relationship:** __________________ **Phone:** ______________

**Name:** _________________ **Relationship:** __________________ **Phone:** ______________

*I understand* that payment of all medical cases is due a the time of services. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child for treatment.
*I understand* that is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company.
*I understand* that I am responsible for any costs.
*I give my consent* to Premium Life Medical Center to administer any immunizations recommended by the American Academy of Pediatrics.
*I hereby grant permission* to Premium Life Medical Center to release any pertinent information to my insurance company or other physicians upon request, and I also authorize payment directly to Premium Life Medical Center.
~~*I acknowledge* that I have reviewed and understand the Health Insurance Portability and Accountability Act (HIPPA) Privacy Notice in our waiting room and how it applies to my child's Protected Health Information.~~
**A copy of the HIPPA Privacy Notices is available upon request. A photographic copy of this authorization is considered effective and as valid as the original.**

✕ Print Name: ________________________
✕ Signature: ________________________
Date: ________________________

**IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS**. I hereby apply for and consent treatment by this Center and its Medical Staff, and authorize all routine Clinic activities, treatment, examinations, and diagnostic services. During my care and treatment, I understand that various types of tests and diagnostic treatment (Procedures) may be necessary. These procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risk and the alternative (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

*The Procedures may include, but are not limited to the following:*

**Needle Sticks,** such as shot, injections, intravenous line, or intravenous injections (IVs). The material risk associated with these types of Procedure include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissues), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternative of Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

**Physical, test, assessment and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks,

and

other similar procedures. The material risks associated with these types of Procedure include, but are not limited to, allergic reaction, infection, sever loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

**Administration of Medication** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these type of Procedure include, but are not limited to, perforation, punclure, infection allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.

**Drawing, Blood, Bodily Fluids or Tissue Samples** such as those done laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, never damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternative.

I understand that:

The practice of medicine is not exact and that NO guarantees or ASSURANCES HAVE BEEN MADE TO ME concerning the outcomes and/or result of any Procedures. The Healthcare Professional Participation in my care will rely on my document medical history, as well as other information obtained from me, my family or other having knowledge about me, in determining whether to perform or recommend the procedures; therefore, I agree to provide and complete information about my medical history and conditions.

I may withdraw my consent for any test or procedure and any time.

**By signing this form:**

- I consent to Healthcare Professionals performing Procedures as they deem necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained.
- I acknowledge that I have been informed in general term of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- I consent to the observation and participation of personnel-in-training and students in my care and treatment.
- I consent to the disposal by hospital authorities of any specimens, tissue or parts that may be removed from the body during my treatment.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign an additional Informed Consent document.

**NOTICE OF PRIVACY POLICIES FOR Premium Life Medical Center**

639 Beaver Ruin Rd Suite A,
Lilburn GA 30047
770-837-2426

**Notice of Health Information Practices**

THIS NOTICE OF HEALTH INFORMATION PRACTICES
DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INDORMATION
PLEASE REVIEW IT CAREFULLY

**Introduction**

It is important to us that you understand what information we collect about you and how it is used. We want you to know that we limit the collection and disclosure of information to only that which we believe is necessary to serve you and administer our business. This Notice is effective November 1, 2007, and applies to all protected health information as defined by federal regulations.

**Understanding Your Health Record/Information**

Each time you visit the clinic, a record of your visit is made. This record contains your symptoms, examination and test results, diagnosis, treatment, and plan for future care or treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

1. A Basis for planning your care and treatment.
2. A means of communication among the many health professionals who contribute to your care.
3. A legal document describing the care you received.
4. A way that you or a third-party payer can verify that services billed were those actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research.
7. A source of information for public health, officials charged with improving the health of this state and the nation.
8. A source of data for our planning and marketing.
9. A tool with which we can assess and continually work to improve the care we render and the outcome we achieve.
10. A source of supporting data, which allows us to receive state and federal funding to provide public health services.

*Understanding what is in your record and how your health information is used helps you to ensure its accuracy. You can better understand who, what, when, Where, and why others may access your health information. It allows you to make more informed decisions when authorizing disclosure to others.*

**Your health Information Rights**

Although your health record is the property of the Premium Life Medical Center the information belongs to you. You have the following rights:

1. To receive a paper copy of this notice of information practices upon request.
2. To inspect and/or receive a copy of your health record.
3. To amend your health record.
4. To receive an accounting of disclosures of your information.
5. To request communications of your health information by other means or at other locations.
6. To request a restriction on certain uses ad disclosures of your information
7. To revoke your authorization to e or disclose your health information except to the extent that action has already been taken.

**Our Responsibilities**

Premium Life Medical Center Required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice of our legal duties and privacy practices regarding information we collect and maintain about you.

3. Abide by the terms of this notice.
4. Notify you if we are not able to agree to a requested restriction.
5. Agree to reasonable request from you deliver health information in another way or at other locations.
We reserve the right to change our practice and to make those changes effective for all protected health information we maintain. Should Our information Practices change we will post the revised notice in our family and provide you with a copy on request.
We will not use or disclose your health information without your permission except as described in this notice. We will also discontinue using or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

| **Patient Signature:** | **Date:** |
|---|---|
| | |

**Cancellation/ No Show Policy**

Missed appointments (no show) affect our ability to provide timely attention to our patients. If you are unable to make your appointment, we respectfully ask that you notify our clinic **at least 24 hours in advance.** If you fail to attend your appointment, you will be charged **a $20.00 no show fee. "No show" fees** may be billed to the patient. This fee is not covered by insurance.
Premium Life Medical Central may waive the no show fee if a **new appointment is scheduled within 10 days.**
Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.
By signing below, you acknowledge that you have received this notice and understand this policy.

| **Patient Signature:** | **Date:** |
|---|---|
| | |