HEALTHWISE INTERNAL MEDICINE

James L. Fisher, M.D. • Darlene L. Dotson, FNP-C
140 Lacy Street, Suite A
Marietta, Georgia 30060
770.422.1985 (office) • 770.422.2814 (fax)

Patient Information

Name: _____SSN: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____

_____

_____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Primary Insurance

Insurance Company: _____

Insured's Name: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Secondary Insurance

Insurance Company: _____

Insured's Name: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____

Assignment and Release

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for the services rendered. I further authorize HealthWise Internal Medicine to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in medical status.

Signature _____ Date: _____

Family History

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if your blood relatives had any of the following:		Relationship to You
Mother						Arthritis, Gout	
Father						Asthma, Hay Fever	
Brother(s)						Cancer	
						Chemical Dependency	
						Diabetes	
Sisters(s)						Heart Disease, Strokes	
						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Serious Illnesses and Injuries

Serious	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? If yes, please list dates.

Pregnancies		
Year of Birth	**Date of Birth**	**Complications, if any**

Health Habits		
Check (✓) which substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Alcohol	
	Drugs	
	Other	

Occupational Hazards	
Occupation:	
Check (✓) if you work exposes you to any of these situations:	
	Stress
	Heavy lifting
	Hazardous Substances
	Other

Symptoms

GENERAL

□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of sleep
□ loss of weight
□ Nervousness
□ Numbness
□ Sweats

GASTROINTESTINAL

□ Appetite poor
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain

EYE, EAR, NOSE, THROAT

□ Bleeding gums
□ Blurred Vision
□ Crossed Eyes
□ Difficulty Swallowing
□ Double Vision
□ Earache
□ Ear discharge
□ Hay Fever
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Ringing in ears

MUSCLE/JOINT/BONE

Pain, Weakness, numbness in:

□ Arms
□ Back
□ Feet
□ Hands
□ Hips
□ Legs
□ Neck
□ Shoulders

GENITO-URINARY

□ Blood in Urine
□ Frequent Urination
□ Lack of Bladder Control
□ Painful Urination

CARDIOVASCULAR

□ Chest Pain
□ High Blood Pressure
□ Irregular Heartbeat
□ Low Blood Pressure
□ Poor Circulation
□ Rapid Heartbeat
□ Swelling of Ankles
□ Varicose Veins

SKIN

□ Bruise Easily
□ Hives
□ Itching
□ Change in Moles
□ Rash
□ Scars
□ Sores That Won't Heal

Symptoms (continued)

WOMEN ONLY	MEN ONLY
□ Abnormal Pap Smear	□ Breast lump
□ Bleeding between periods	□ Erection difficulties
□ Breast lump	□ Lump in testicles
□ Extreme menstrual pain	□ Penis discharge
□ Hot flashes	□ Sore on penis
□ Vaginal discharge	□ Other
□ Nipple discharge	
□ Painful intercourse	
Date of last menstrual period _____	
Date of last pap smear _____	
Date of last mammogram _____	
Are you pregnant? _____	
Number of children _____	

Medications

List all medications you are currently taking.

Allergies

Please state all medical and environmental allergies.

Conditions			
Check (✓) symptoms you currently have or have had in the past year.			
□ AIDS	□ Chemical Dependency	□ High Cholesterol	□ Prostate Problem
□ Alcoholism	□ Chicken Pox	□ HIV Positive	□ Psychiatric Care
□ Anemia	□ Diabetes	□ Kidney Disease	□ Rheumatic Fever
□ Anorexia	□ Emphysema	□ Liver Disease	□ Scarlet Fever
□ Appendicitis	□ Epilepsy	□ Measles	□ Stroke
□ Arthritis	□ Glaucoma	□ Migraine Headaches	□ Suicide Attempt
□ Asthma	□ Goiter	□ Miscarriage	□ Thyroid Problem
□ Bleeding Disorders	□ Gonorrhea	□ Mononucleosis	□ Tonsillitis
□ Breast Lump	□ Gout	□ Multiple Sclerosis	□ Tuberculosis
□ Bronchitis	□ Heart Disease	□ Mumps	□ Typhoid Fever
□ Bulimia	□ Hepatitis	□ Pacemaker	□ Ulcer
□ Cancer	□ Hernia	□ Pneumonia	□ Vaginal Infections
□ Cataracts	□ Herpes	□ Polio	□ Venereal Disease

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completing of this form.

Signature_____ **Date**_____

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Treatment Agreement

Please agree to be our partner in your healthcare by reading and signing this form.

Laboratory studies and/or x-rays deemed necessary for evaluation and treatment of my illness or maintenance of my health status have been ordered and given to me.

I understand that it is my responsibility to get these studies done. If I decide not to have them done, the responsibility does not fall on Dr. Fisher or his staff.

If I do not hear from the office with five (5) business days for x-rays results or two (2) weeks for lab results, I will contact the office.

Name: _____

Signature: _____

Date: _____

** This agreement is binding as long as you remain a patient with this practice**

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Authorization for Release of Confidential and Privileged Information

This information may include copies of any/all of the following: medical records, x-ray and laboratory results, psychiatric records and/or alcohol abuse records, sexually transmitted disease results, records necessary to process insurance claims and any or all medical information that is required for any health care related to utilization review or quality assurance activities. This authorization may also include any and/or all information related to HIV or AIDS counseling or treatment.

If the patient is a minor (under 18 years of age), incapacitated, or adjudicated incompetent, authorization must be signed by next of kin or executor of estate.

_____	_____	_____
Patient Name (Please Print)	***Date of Birth***	***Social Security Number***

I authorize: _____

_____

_____

_____

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Permission for Electronic Communication

I, _____, give HealthWise Internal Medicine staff my permission to relay my laboratory studies and/or x-ray results on my voicemail and/or answering machine.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Notice of Privacy Practices

This notice takes effect on 1/28/03 and remains in effect until it is replaced by this office.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights to certain duties we have regarding the use and disclosure of medical information.

Law Requires Us to:

2. OUR LEGAL DUTY

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of this notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

(Continued on next page)

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose of medical information. Not every disclosure will be listed. However, we have listed all of the different way we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use the medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our best professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, prescriptions, samples, referrals, medical supplies, x-ray, or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

(Continued on next page)

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose our use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for corrective institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correction institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when law authorizes us to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of

HealthWise Internal Medicine's Notice of Privacy Practices and have been provided an opportunity to review it.

Printed Name: _____

Signature: _____

Date: _____