Family Practice OF ATLANTA
Better Health For A Better Life

# Health History Questionnaire

Today's Date:________________ Patient Name: ____________________________________ DOB: ____________ Age: _________

Date of Last Physical: _________________ Reason for Visit: __________________________________________________________

## Symptoms

Check (√) symptoms you ***currently have*** or have had in the past year.

**GENERAL**
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of sleep
- □ Loss of weight
- □ Nervousness
- □ Numbness
- □ Sweats

**MUSCLE/JOINT/BONE**

Pain, weakness, numbness in:
- □ Arms
- □ Hips
- □ Back
- □ Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders

**GENITO-URINARY**
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

**GASTROINTESTINAL**
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

**CARDIOVASCULAR**
- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

**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
- □ Sinus problems
- □ Vision- Flashes
- □ Vision- Halos

**SKIN**
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won't heal

**MEN only**
- □ Breast lump
- □ Erection difficulty
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

**WOMENE only**
- □ Abnormal pap smear
- □ Bleeding between periods
- □ Breast lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other

Date of last menstrual period ___________

Date of last Pap smear_________________

Have you had a mammogram?____________

Are you pregnant? __________

Number of children _________

## Conditions

Check (√) symptoms you ***currently have*** or have had in the past year.

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bleeding disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ HIV Positive
- □ Kidney disease
- □ Liver disease
- □ Measles
- □ Migraine headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problem
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease

## Medications

List medications you are currently taking.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Pharmacy Name: ___________________________ Phone: __________________________

## Allergies

__________________________

__________________________

__________________________

## Family History

Fill in health information about your immediate family

| Relation | Age | Age of Death | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| | | | |
| | | | |
| | | | |
| Sisters | | | |
| | | | |
| | | | |
| | | | |

Check ( ) if, your blood relatives had any of the following:

| | Disease | Relationship to you |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Hospitalizations

| Year | Hospital | Reason for Hospitalization & Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ◻ Yes ◻ No
If yes, please give approximate dates

| Serious Illnesses/Injuries | Date | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Pregnancies

| Year of Birth | Sex of Birth | Complications if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Health Habits

Check (√) which you use and how much use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Street Drugs | |
| | Other | |

## Occupational

Check (√) if your work exposes you to:

| | | | |
|---|---|---|---|
| | Heavy Lifting | | Hazardous Substances |
| | Stress | | Other |

Occupation_____________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_______________________________________ Signature of Patient, Parent, Guardian or Personal Representative

_______________________________________ Date

_______________________________________ Please print name of Patient, Parent, Guardian or Personal Representative

_______________________________________ Relationship to Patient

_______________________________________ Reviewed By

_______________________________________ Date

# FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

**PATIENT NAME:________________________________________ DOB: ________________**

Thank you for choosing Family Practice of Atlanta Dr. Sondi Moore-Waters/Dr. Anu Gulati as your healthcare provider. We are committed to providing you the best available medical care.

Our staff will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy and assignment of benefits as well as complete our patient information form prior to seeing the physician. Payments for services are due at the time services are rendered. We accept cash, check, credit cards Visa, Discover and MasterCard. We will be happy to help you process your insurance claim for reimbursement. In special instances, we may accept assignment of benefits. However, you must understand that:

1. Your insurance policy is a contract between you, and your employer and the insurance company. Our relationship is with you. We cannot be involved in disputes between you and your insurer regarding deductibles, copayments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with most local managed care plans. We follow their guidelines for reimbursements and submission of claims for services rendered. Any contractual provider discount will be deducted from you balance.
2. All charges are your responsibility-whether you're insurance company pays or does not pay. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and copayments, are due at beginning of treatment.
4. If you have a high deductible health plan, we will collect payment at time of visit.
5. If you insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. After all if your insurance does not pay you are responsible for payment.
6. Returned checks and balances older than 90 days are subject to collection agency placement, collection fees, and reasonable attorney fees. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so that we may assist you I the management of your account.
7. It is your responsibility as the patient to give us any updated information regarding insurance/ address/ or phone number changes.

**Signature of patient:____________________________ Date____________________________**

# Appointment Cancellation Policy

# Acknowledgement

I have been advised and acknowledge that I am responsible for cancellation fee(s) for scheduled and confirmed appointments not cancelled within 24 hours*.  The cancellation fees are as follows:

- ☐ $ 25.00  Office Visit
- ☐ $ 50.00  Physicals
- ☐ $ 50.00  IUD
- ☐ $ 50.00  Stress Test
- ☐ $ 25.00  Allergy Testing/Immunotherapy
- ☐ $100.00  Ultrasound (48 hour cancellation notification required)

***The Ultrasound procedure requires a 48 hour cancellation.**

______________________________ ______________________________
Print Full Name Date

______________________________
Signature

# PATIENT CONSENT
# FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Family Practice of Atlanta to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Family Practice of Atlanta's Notice of Privacy Practices provides a more completed description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Family Practice of Atlanta reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 1428 Scott Blvd, Decatur, Georgia 30030 or by visiting the website at www.familypracticeofatlanta.com.

With this consent, Family Practice of Atlanta may call my home or other alternative location and leave a message on voice mail or in person in reference to an items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results among others.

With this consent, Family Practice of Atlanta may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Family Practice of Atlanta may email to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Family Practice of Atlanta restrict how it uses or discloses my personal health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Family Practice of Atlanta's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Practice of Atlanta may decline to provide treatment to me.

______________________________ DOB: ______________________
Print Patient/Parent/Guardian/Personal Representative Name — Patient

______________________________ Date: ______________________
Signature of Patient/Parent/Guardian/Personal Representative

*Family Practice* OF ATLANTA
*Better Health For A Better Life*

Patient Name: ______________________
Date of Visit: ______________________
Care Provider: ______________________

# PATIENT SURVEY

**1. I was able to schedule my appointment in a reasonable amount of time.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

2. **When I called the office, I received the help or advice I needed in a timely and courteous manner**.

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**3. The front office staff met and greeted me promptly and courteously.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**4. When I checked in, the staff member collected my payment and verified my billing information.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**5. The Medical Assistant greeted me promptly and courteously.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**6. The provider listened to me and my problems, showing respect and concern for what I had to say.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**7. The provider explained things in a way I could understand.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**8. The provider spent enough time with me at this visit to discuss the problem I came in for.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**9. If I received a referral to a specialist, it was handled in a timely manner and to my satisfaction.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**10. I was satisfied with the service from staff, my provider, and the overall quality of my visit.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**11. I would recommend you medical office to others.**

○ Strongly Agree ○ Agree ○ Disagree ○ Strongly Disagree ○ N/A

**12. How did you hear about our practice?**

○ Referral ○ ZocDoc ○ Website ○ Yellow Pages ○ Other ____________

**Who referred you:** ________________________________

**13. Comments or suggestions for improvement of my visit:**

________________________________________________________________
________________________________________________________________
________________________________________________________________