Integrative Physicians of Atlanta 4880 Lawrenceville Highway Tucker, GA 30084 (770) 864-9602

Today's Date:	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status: Single Mar Div Sep
Street address:	Birth date:	Social Security no.:	Home phone no.: ( )
P.O. box:	City:	State:	ZIP Code:
Referred to clinic by :			
Family	Friend	Insurance Plan	Yellow Pages	Work:	Hospital:	Other:
Other family members seen here:						

INSURANCE

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: ■ ■	Address (if different):	Home phone no.: ( )
Is this person a patient here?	Yes No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( ) ■

Please indicate primary insurance	BCBS	United Healthcar	Cigna	Aetna	Other
If other please indicate:					

Subscriber's name:	Subscriber's S.S. no.: ■ ■	Birth date: ■	Group no.: ■	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	Self	Spouse	Child	Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	Self	Spouse	Child	Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize INTEGRATIVE PHYSICIANS OF ATLANTA or insurance company to release any information required processing my claims.

Patient/Guardian signature *Date*

Health History

Name_____ **Date**_____
DOB_____

Check any of following medical problems that you have had.

☐ Abn Weight Loss	☐ Rheumatic Fever	☐ Arthritis or joint pain
☐ Abn Weight Gain	☐ High Cholesterol	☐ Gout
☐ Excessive Fatigue	☐ Heart Failure	☐ Broken Bones
☐ Insomnia	☐ Heart Attack	☐ Rashes
☐ Anemia	☐ High Blood Pressure	☐ Hives
☐ Cancer or Tumor	☐ Breathing Problems	☐ Moles
☐ Glasses/ Contacts	☐ Frequent Bronchitis	☐ Seizure
☐ Glaucoma	☐ Emphysema	☐ TIA
☐ Cataracts	☐ Pneumonia	☐ Stroke
☐ Vison problems	☐ Asthma	☐ Numbness
☐ Hearing Loss	☐ Heartburn	☐ Weakness
☐ Ear Problems	☐ Ulcer Disease	☐ Memory Loss
☐ Ringing in Ears	☐ Gallbladder Disease	☐ Headaches
☐ Allergies	☐ Blood in Stool	☐ Depression
☐ Frequent Sinus Infections	☐ Hepatitis	☐ Anxiety/Panic Attacks
☐ Dentures	☐ Diarrhea, Constipation	☐ Suicide Attempt
☐ Dental Problems	☐ Hemorrhoids	☐ Physical Abuse
☐ Recurrent Sores In mouth	☐ Abdominal Pain	☐ Sexual Abuse
☐ Angina	☐ Colon Polyp	☐ Mental Illness
☐ Frequent Chest Pain	☐ Urinary Frequency	☐ Diabetes
☐ Irregular Heartbeat	☐ Bladder Infections	☐ Thyroid Disease
☐ Heart Murmur	☐ Prostate Problems	☐ Sexually Transmitted Diseases
☐ Kidney Problems	☐ Urinary Frequency	
☐ Abnorrmal Pap Smear	☐ Bladder Infections	
☐ Abnormal Mammogram	☐ Prostate Problems	
☐ Breast Lump	☐ Urinary Incontinence	
___#Pregnancies ___Live Births ___Miscarriages ___Abortions	Have you been exposed to or do you have a close family member with… ☐ HIV/AIDS ☐ Hepatitis ☐ TB	

Please list the last year in which you have had any of the following:

Physical Exam_____	Sigmoidoscopy/Colonoscopy (Circle which one)____	Cholesterol___
Pap smear_____	Stool Cards for Colon Cancer____	Dental Visit___
Mammogram_____	Rectal/Prostate Exam____	Eye Exam____
Testicular Exam_____	Bone Density____	Stress Test____

Please describe your use of tobacco products. (Check all that apply)
None_____ Cigarettes_____ Smokeless Tobacco_____ Pipe_____ Cigars_____

How much do you or did you smoke_____ per day? How often _____?
Do you wish to quit? Now_____ Soon_____ Eventually_____ Never_____
Have you quit? _____ When? _____

How much alcohol do you drink weekly on average? _____
Do you have a problem with alcohol? Yes_____ No_____

Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc.)? Yes_____ No_____

How much caffeine do you drink daily (include coffee, tea, colas)?_____

Are you sexually active? ____ Are your partners male, female, or both? (Circle)
Do you use contraception? None__ Rhythm__ Condoms__ Pill__ Vasectomy__ IUD__
Diaphragm__ Tubal Ligation__
Do you practice safe sex? Never__ Sometimes__ Always__

Please check if there is a history of any of the following diseases in your family.
Heart Disease__ Diabetes__ Colon Cancer__ Osteoporosis__ Prostate Cancer__
Breast Cancer__ Ovarian Cancer__ High Cholesterol__ Skin Cancer__

Please fill in the following family history. Age (or age at death)
Mother_____
Father_____
Siblings_____
Children_____

Other medical problems:
1._____
2._____
3._____
4._____

List ***all*** surgeries you have had:
1._____
2. _____
3._____
4. _____

List ***all*** allergies:
1_____
2._____
3._____
4._____

List medications, vitamins, and supplements you are currently taking:
1._____
2._____
3._____
4._____

Patient's Signature_____ Date_____

INTEGRATIVE PHYSICIANS OF ATLANTA

4880 Lawrenceville Highway, Suite 13
Tucker, GA 30084
(770) 864-9602

AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED MEDICAL RECORDS

TO: _____

At the request of the undersigned, you are hereby authorized, requested and directed to disclose protected health information about me as described below for the purpose of evaluation and/or treatment with a Doctor at INTEGRATIVE PHYSICIANS OF ATLANTA.

1. The following specific person or class of persons or facility is authorized to make the requested disclosure: any and all medical doctors, hospitals, emergency treatment centers, private health care facilities, chiropractors, physical therapists, or any other persons or facilities who have provided any health related treatment, diagnosing testing, or test analysis on behalf of the undersigned or who maintain any documentation pertaining to the physical and/or mental condition of the undersigned.

2. INTEGRATIVE PHYSICIANS OF ATLANTA may receive disclosure of protected health information about me.

3. The specific information that should be disclosed is: documentation pertaining to the physical and mental condition of the undersigned, including patient history, examination, diagnosis, treatment, prognosis, opinion, x-ray and complete treatment file. I understand that this disclosure may include psychiatric, drug/alcohol, and/or HIV testing results, and/or AIDS related information. You are further authorized, requested and directed to discuss any relevant knowledge you may have related to any of the above-referenced information with the Doctor(s) of INTEGRATIVE PHYSICIANS CENTERS OF ATLANTA.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying INTEGRATIVE PHYSICIANS OF ATLANTA in writing of my desire to revoke it. However, I understand that any action already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that any medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization. This authorization shall remain in effect regardless of the lapse of time, unless revocation is submitter to INTEGRATIVE PHYSICIANS OF ATLANTA in writing as stated above.

6. This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of my PHI to/from INTEGRATIVE PHYSICIANS OF ATLANTA.

Patient's Name: _____ Date: _____

Guardian's Name: _____ For: ☐ Minor ☐ Mental/Physical disable

Patient/Guardian's Signature: _____

Patient's DOB: _____

Patient's SSN _____-_____-_____ Guardian's SSN: _____-_____-_____

Witness's: _____ Date: _____

INTEGRATIVE PHYSICIANS OF ATLANTA

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI to be made by alternative means, such sending correspondence to the individual's office instead of their home.

For appointment reminders, rescheduling or billing, I authorize the staff of INTEGRATIVE PHYSICIANS OF ATLANTA to contact me at any of the phone numbers given to them. For all other matters I wish to be contacted in the following manner (check all that applies):

CHECK AT LEAST ONE

☐ Home Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Cell Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

CHECK AT LEAST ONE

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number _____

☐ Email: _____
_____
_____

☐ Other: _____
_____
_____

_____
Patient Signature **Date _____**

_____
Patient Name (Print) **Date_____**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Addresses or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

Integrative Physicians of Atlanta

Blood Testing Consent Form

Craig Sampson M.D.

CONSENT TO DRAW BLOOD

DATE: _____

RE: _____

TO: **CRAIG SAMPSON M.D.**

I, _____, authorize the above treating physician to draw blood for testing.

Patient Signature: _____

Date: _____