Christ the King Medical Center
3531 – 3533 Highway 81 South
Loganville, GA 30052

PATIENT REGISTRATION

Today's date:____ PCP: Constance George-Adebayo MD

PATIENT INFORMATION

Patient's Last Name:	First:	Middle Initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (circle one): Single / Mar / Div / Sep / Widow
Social Security Number: - -	Birth Date: / /	Age:	Sex: ☐ Male ☐ Female	Number of Children (if applicable):
Address 1	City:	State:	Zip Code :	
Address 2				
Email Address:	Home Phone: ( )	Cell Phone: ( )	Preferred Method of Contact: ☐ Home ☐ Cell ☐ Email	
Occupation:	Employer:	Work Phone: ( )		
Chose clinic because/Referred to clinic by (please check as many as apply):	☐ Dr. _____________	☐ Internet	☐ Insurance Plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Health Fair	☐Other:
Other family members seen here:				
I give my consent for this office to: Retrieve my previous prescription history from other providers: ☐ **Yes** ☐ **No** Upload my history of immunizations received at this clinic: ☐ **Yes** ☐ **No**				

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no. (if different): ( )
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:			S.S. No.:

(Please present insurance cards to receptionist. Do not complete the section below if Insurance Card is present)

PRIMARY Insurance Name:			
Name of Insured:	Insured's SS No.:	Birth date: / /	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Pharmacy/Facilities Information

Pharmacy Name:		Phone: ( )	
Address:	City:	State:	Zip:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone: ( )	Work Phone: ( )

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 Christ the King Medical Center or my insurance company to release any information required to process my claims.

Patient/Guardian signature: ____ *Date:* ______________________

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NEW PATIENT HISTORY

NAME: ____ **TODAY'S DATE:** ____________________

REASON FOR YOUR VISIT? ____

HISTORY OF ILLNESS - ***MUST ANSWER ALL THE FOLLOWING QUESTIONS***

WHERE IS YOUR PROBLEM? ____

WHERE WERE YOU WHEN YOU NOTICED THIS PROBLEM?_______________________________________

HOW LONG HAVE YOU HAD THIS PROBLEM? ____

HOW SEVERE IS YOUR PROBLEM? ____

WHAT MAKES IT BETTER OR WORSE? ____

ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
HEART DISEASE	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS OR SURGERIES

DATE	REASON	DATE	REASON

REPRODUCTIVE HISTORY

WOMEN: LMP ____________ LAST PAP SMEAR ____________
PREGNANT? ☐ YES ☐ NO
PLANNING PREGNANCY? ☐ YES ☐ NO
NUMBER OF CHILDREN YOU HAVE HAD? _______
MENSTRUAL DYSFUNCTION ☐ YES ☐ NO

MEN: SEXUAL DYSFUNCTION _________ PENILE DISCHARGE _______
SEXUAL HISTORY/VENEREAL DISEASE ______________________
PROSTATE DISEASE _____________________

PAST MEDICAL HISTORY

- ☐ HEADACHE
- ☐ SHORTNESS OF BREATH
- ☐ HEART PALPITATIONS
- ☐ HEART MURMUR
- ☐ CHEST PAIN
- ☐ DIZZINESS/FAINTING
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ ALLERGIES/HAY FEVER
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ PNEUMONIA
- ☐ ULCER
- ☐ GI DISORDER
- ☐ GALL BLADDER DISEASE
- ☐ DIABETES
- ☐ BOWEL IRREGULARITY
- ☐ VENEREAL DISEASE
- ☐ KIDNEY PROBLEMS
- ☐ HEPATITIS
- ☐ ANEMIA
- ☐ ARTHIRITS
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ GOUT
- ☐ HYPERTENSION
- ☐ HEART DISEASE
- ☐ CANCER
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ MUMPS
- ☐ MEASLES
- ☐ CHICKEN POX
- ☐ LUNG DISEASE
- ☐ SICKLE CELL/CYSTIC FIBROSIS
- ☐ SEIZURES
- ☐ TUBERCULITIS
- ☐ HIV / AIDS
- ☐ BLOOD TRANSFUSION

SOCIAL HISTORY

☐ SNUFF: AMOUNT DAILY _____________________ ☐ SMOKE: AMOUNT DAILY ____

☐ EXERCISE ROUTINE __________________________ ☐ ALCOHOL: TYPE/AMOUNT ______________________________________

Provider's Signature		Date		Provider's Signature		Date	

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Assignment of Benefits Financial Agreement

PATIENT'S NAME: ______________________ **DATE OF BIRTH:** ______________________

I hereby give authorization for payment of insurance benefits to be made directly to Christ the King Medical Center, and my assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize the use of my signature on all insurance submissions. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. The above-named physician may use my healthcare information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. I understand that as part of my healthcare, Christ the King Medical Center, PC originates, records, and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, as well as claims and payment status. I understand that this health information may be used or disclosed by Christ the King Medical Center PC for: treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnoses and surgical information to my bill, a means by which a third party can verify that services billed were actually *provided*, and a tool for routine health care operations such as assessing quality and reviewing the competence of health care Professionals.
2. I acknowledge that I have provided Christ the King Medical Center PC Notice of Privacy Practices that provides a more complete description of information uses and disclosures and my rights regarding my medical information. I understand that Christ the King Medical Center PC reserves the right to change its Notice of Privacy Practices and at my request, will make available to me, a copy of any revised notice.
3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations and that Christ the King Medical Center PC is not required to agree to the restrictions requested. If it does, it is bound by such restrictions.

FOR CONFIDENTIAL COMMUNICATION:

We will try to contact you by any of the phone numbers provided to us in this registration form or verbally. For appointments, we will leave messages at your home number or on your voice message.

DISCLOSURES OF PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVES

If you wish to have your medical or financial information discussed with anyone else other than yourself. Please list them below. If you do not wish to have your medical or financial information discussed with anyone please leave the names and phone number options blank.

Name	Phone Number
1.	
2.	
3.	

By signing below, I acknowledge that I have read and understand the information on this page. A copy of this form will be as valid as the original.

Print Name of Patient of Legal Guardian	Signature	Date	Relationship to Patient

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No Show Policy

I______________________________, understand that if I fail to arrive to a scheduled appointment I will be charged a $50.00 No Show Fee. If I need to reschedule, for whatever reason, I will call the office 24 hours in advance at 770 554 8015 in order to avoid being charged this No Show Fee.

Signature:______________________________
Date: ______________________________

Phone: 770.554.8015 Fax: 770.554.8042