AUGUSTA MEDICAL CARE

PLEASE PROVIDE INSURANCE CARD(S) & PHOTO ID OR DRIVERS LICENSE

Today's Date: ____________ SS #:____________________ **DOB:** ______________

PATIENT INFORMATION:

Patient's Name: ____

(First Name) (M.I.) (Last Name)

I preferred to be addressed as / My nickname is: ________________________ Sex: ☐ M ☐ F

Address: ____

(Street Address) (City/State) (Zip Code)

Home Phone: (____) ________________

Cell Phone: (____) ________________

Email: _________________________

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

Did a Physician Refer You? ☐ NO ☐ YES Name: ______________________

Who is your Primary Care Physician: ______________________________________

How did you find us? Were you referred by:

Physician______________________ Insurance Book______ Internet ________

Family or friend *(name)*: ________________ Prior Patient________ Newspaper Ad___

Other *(please specify)* __________________ Saw our Billboard____ Mailing _________

FOR MINORS ONLY: PARENT OR LEGAL GUARDIAN INFORMATION

Parent or Legal Guardian Name: ________________________________

Home Phone: (____) ____________ Work Phone: (____) ____________ Cell: (____)____________

DEMOGRAPHICS:

1) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than One Race ☐ Refuse to Report

2) **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Unknown

3) **Preferred Language:** ☐ English ☐Spanish ☐Creole ☐ Other

4) **Preferred Notification Method:** ☐ Postal Mail ☐ Phone ☐ Email

5) **Marital Status:** ☐ M ☐S ☐ D ☐W ☐ Full time student

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? ________________________

Relationship to Patient: ________________Phone: (____)____________

PATIENT EMPLOYMENT INFORMATION

Patient's Employer Name & Address: ________________________________

Employer's Phone (______)________________ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

INSURANCE COVERAGE: **(we will need to make a copy of your cards – please provide your cards)**

Primary Company Name:__________________________

Secondary Company Name:________________________

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

☐ Same as Emergency Contact.

☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

☐ I authorize release of medical information to my primary care, referring doctors and consultants.

☐ I authorize you to send me practice related emails.

☐ These are the additional persons I give my permission to disclose information about my medical treatment:

Name: ______________________ Relationship: ______________ Phone #: (___) ______________

Name: ______________________ Relationship: ______________ Phone #: (___) ______________

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?

☐ **YES** ☐ **NO**

PHARMACY INFORMATION (we transmit all prescriptions through the computer!)

Local Pharmacy Name: ______________________ Phone #: (___) ______________

Address: ____

Mail Order Pharmacy Name: ______________________ Phone #: (___) ______________

Address: ____

CO-PAYMENT AND DEDUCTIBLE ARE DUE WHEN SERVICES ARE RENDERED: NO EXCEPTIONS PLEASE, THANK YOU!

Augusta Medical Care
3642 Wheeler Road
Phone # (706)496-2573

Kashif Naseeem, M.D.
Augusta, Ga. 30909

Authorization for Use and Disclosure of Protected Health Information

Patient Identification:

Printed Name:_ DOB:
Address: ______________________________

SSN: ______________________ Telephone: ______________________

Information To Be Released — Covering Periods of Healthcare:

From (date) ______________ to (date) ______________
From (date) ______________ to (date) ______________

Please choose type of information to be released:

- ◯ Entire Medical Record
- ◯ History and Physical exam
- ◯ Laboratory test results/reports
- ◯ Operative reports
- ◯ Pathology report
- ◯ Consultation reports
- ◯ X-ray report
- ◯ Emergency room record
- ◯ Discharge Summary
- ◯ Progress Notes
- ◯ X ray -films/images
- ◯ Itemized bill
- ◯ Other, (specify) ______________________________

Purpose of Request:

Treatment or Consultation At the request of the patient El Billing or claims payment
◯ Other (specify) ______________________________

Person Authorized to Receive Information

Name: Kashif Naseem, M.D. Phone: (706)496-2573
Address: 3642 Wheeler Road, Augusta GA 30909

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or sensitive information, I agree to its release

Check one: yes☐ no☐ ______________ Initials

Time Limit and Right to Revoke Authorization:
Except to the extent that the action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to: *Augusta Medical Care, 3642 Wheeler Road, Augusta GA 30909*

Re-disclosure:
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Probability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that *Augusta Medical Care* may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I **authorize Augusta Medical Care to use and disclose the protected health information specified above.**

Signature: ______________________________ Date: ______________
Authority to sign if not patient: ______________________________
Identity of Requestor Verified via [ ] Photo ID [ ] Matching Signature [ ] Other:______________
Verified by: ______________________________

Pain Treatment Agreement

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Dr. Kashif Naseem not providing ongoing care for me.

I, ____, agree to undergo pain management by Dr. Kashif Naseem.

I agree to the following statements:

_______I will not accept any narcotic prescriptions from another doctor.

_______I will be responsible for making sure that I take medications as instructed and do not run out of them on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.

_______I understand that I must keep my medications in a safe place.

_______I understand that Dr. Kashif Naseem will not supply additional refills for the prescriptions of medications that I may lose.

_______If my medications are stolen, Dr. Kashif Naseem will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.

_______I will not give my prescriptions to anyone else.

_______I will only use one pharmacy.

_______I understand that I will be given periodic drug testing

_______I will keep my scheduled appointments with Dr. Kashif Naseem unless I give notice of cancellation 24 hours in advance.

_______I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by Dr. Kashif Naseem.

_______I understand that Dr. Kashif Naseem believes in the following "Pain Patients' Bill of Rights."

You have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making

CLINICAL INFORMATION FROM PATIENTS

YOUR MEDICATION ALLERGIES

Medication ______________________ Reaction: ______________________

Medication ______________________ Reaction: ______________________

Medication ______________________ Reaction: ______________________

Medication ______________________ Reaction: ______________________

Medication ______________________ Reaction: ______________________

CURRENT MEDICATIONS: PLEASE INCLUDE OVER-THE-COUNTER NON-PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL DIETARY SUPPLEMENTS****

Medication	Dosage	Frequency	Reason for Taking

MEDICAL HISTORY

REASON(S) FOR TODAY'S VISIT

1. ______________________
2. ______________________
3. ______________________

DO YOU HAVE A HISTORY OF HEPATITIS OR HIV? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐NO If yes, due date ______________

Are you trying to get pregnant? ☐ YES ☐ NO

Skin Cancer:

- Melanoma; Date:______________
  Location:______________
  Which Dr has Records? ________________
- Squamous Cell Carcinoma
- Basal Cell Carcinoma
- Actinic Keratosis (pre-skin cancer)
- Other:________________________

□ ***Dermatological Disease:***

- Herpes/Cold Sores
- Psoriasis
- Eczema
- Acne
- Rosacea
- Blistering Disorder:________________
- Healing problems: slow, keloid, bruising
- Other:__________________________

□ ***Immunological Disease:***

- Immune deficiency
- HIV/AIDS
- Lupus or Scleroderma

□ ***Hematology/Oncology:***

- Cancer; type:__________________Year_______
- Bleeding problems

□ ***Rheumatologic Disease:***

- Osteoarthritis
- Rheumatoid Arthritis
- Gout

□ ***Psychological/Emotional Disease:***

- Depression
- Obsessive-Compulsive

□ ***Gastrointestinal Disease:***

- Crohn's Disease, Ulcerative Colitis
- Esophageal Reflux
- Peptic Ulcer
- Esophagitis

□ ***Orthopedic Disease:***

- artificial joint ________________(area)
- When? ________________________________

□ ***Cardiovascular Disease:***

- High Blood Pressure
- Heart problems;________________
- Heart Attack; Date:_____________
- **Pacemaker**
- **Defibrillator**
- prostatic heart valve
- Irregular heartbeat
- High Cholesterol

□ ***Endocrine Disease:***

- Diabetes
- Hyperthyroid
- Hypothyroid

□ ***Neurological Disease:***

- Stroke/Aneurysm
- Seizure/Epilepsy
- Multiple Sclerosis (MS)
- Alzheimer's
- Fainting

□ ***Liver Disease:***

- Hepatitis: type________________
- Jaundice

□ ***Lung Disease:***

- Asthma
- COPD
- Tuberculosis

□ ***Kidney Disease:***

- Poorly functioning kidneys
- Dialysis: Type____________________________

□ ***For Female Patients:***

- Are you pregnant/Planning Pregnancy
- Polycystic Ovary Disease

□ ***Other/Not Listed:***

- Transplant? Y N. What Type? _________
- ______________________________________
- ______________________________________
- ______________________________________

Conditions/Problems	Family Medical History: Which Relatives??
□ Melanoma	
□ Non-Melanoma Skin Cancer	
□ Blistering Disorder	
□ Auto-Immune Disorder	
□ Psoriasis	

□ Occupation________________________________ □ Retired
□ Smoker:___Packs/day □ Non-smoker □ Quit smoking in _____
□ Smokeless Tobacco: □ Y □ N
□ Alcohol use: □ Yes (drinks/week:___________) □ No
□ Recreational Drug use: □ No □ Yes______________________
□ I have traveled outside the United States in the past three months

____ ________________________
Patient's Signature Date