Paces Ferry Medical Group, P.C.

3193 Howell Mill, Suite 223
Atlanta, Georgia 30327
404.351.5262

PATIENT UPDATE FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

INSURANCE INFORMATION

(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.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Medicare ☐ Aetna ☐ Medicaid ☐ BlueCross ☐ Other _____

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 Paces Ferry Medical Group, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: **Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:

☐ Tetanus ☐ Pneumonia
☐ Hepatitis ☐ Chickenpox
☐ Influenza ☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting?			☐ Yes	☐ No
If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
# of meals you eat in an average day?				
Rank salt intake	☐ Hi	☐ Med	☐ Low	
Rank fat intake	☐ Hi	☐ Med	☐ Low	

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans per day?

Alcohol

Do you drink alcohol?	☐ Yes	☐ No
If yes, what kind?		
How many drinks per week?		
Are you concerned about the amount you drink?	☐ Yes	☐ No
Have you considered stopping?	☐ Yes	☐ No
Have you ever experienced blackouts?	☐ Yes	☐ No
Are you prone to "binge" drinking?	☐ Yes	☐ No
Do you drive after drinking?	☐ Yes	☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day

☐ # of years ☐ Or year quit

Drugs

Do you currently use recreational or street drugs?	☐ Yes	☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No

Sex

Are you sexually active?	☐ Yes	☐ No
If yes, are you trying for a pregnancy?	☐ Yes	☐ No
If not trying for a pregnancy list contraceptive or barrier method used:		
Any discomfort with intercourse?	☐ Yes	☐ No
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

Personal Safety

Do you live alone?	☐ Yes	☐ No
Do you have frequent falls?	☐ Yes	☐ No
Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
Would you like information on the preparation of these?	☐ Yes	☐ No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Date of last pap and rectal exam?

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives a patient the right to request all uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing

I wish to be contacted in the following manner. (Check all that apply):

- ☐ Cell phone _____
- ☐ Home Phone _____
- ☐ Okay to leave message with detailed information
- ☐ Leave name/doctor with call back number only
- ☐ Work telephone _____
- ☐ Leave detailed message on work voicemail
- ☐ Leave message with name/doctor and call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address
- ☐ Other _____
- ☐ Email _____

_____

Patient signature Date

_____

Print name Birthdate

Healthcare providers must keep records of PHI disclosures. Information provided will be documented on the test results, progress notes, or patient communication in question.

PACES FERRY MEDICAL GROUP WELLNESS

Your name: _____

Today's date: _____

Your date of birth: _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? _____

2. Are you a female or a male?

☐ Male. ☐ Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Quality of Life Questionnaire

Date: _____

Patient's Name: _____ DOB: _____

Patient's Phone Number: _____ Email: _____

1, Have you ever been diagnosed with Allergies? YES ☐ NO ☐ _____

2. Are you currently taking or have you within the last year taken or have been prescribed any over-the-counter or prescription strength medications for allergies, hay fever, or nasal congestion? YES ☐ NO ☐ _____

If YES, please list all that apply:

_____

_____

3. Have you ever been diagnosed with asthma? YES ☐ NO ☐ _____

4. Is your doctor currently treating your asthma with medications? YES ☐ NO ☐ _____

If YES, please list all that apply:

_____

_____

5. Please note that in the case of seasonal allergies, you may not be experiencing the following symptoms now, but may experience them regularly during a different season of the year.

Please check all that apply:

☐ Stuffy Nose	☐ Sore Throat	☐ Bad Breath
☐ Runny Nose	☐ Cough	☐ Snoring
☐ Nasal Congestion	☐ Post Nasal Drip	☐ Mouth Breathing
☐ Itchy Eyes	☐ Headaches	☐ Nose Bleeding
☐ Watery Eyes	☐ Trouble Sleeping	☐ Sinus Pain
☐ Itchy Throat	☐ Fatigue	☐ Loss of Taste/Smell

Patient Name _____

Date of Birth _____ Today's Date _____

Please check the appropriate box if you are currently experiencing any of these symptoms, and/or if you have experienced them in the last 7 to 14 days.

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Frequent Urination	☐	☐
Fatigue (Tiredness)	☐	☐
Heartburn	☐	☐
Increased Hunger	☐	☐
Nausea	☐	☐
Numbness & Tingling in Hands or Feet	☐	☐
Vomiting	☐	☐

SUDOMOTOR DYSFUNCTION (SUDOD)		
Burning Sensation	☐	☐
Difficulty Digesting Food	☐	☐
Dizziness or Fainting	☐	☐
Exercise Intolerance	☐	☐
Sexual Difficulties	☐	☐
Sweat Abnormalities	☐	☐
Tingling Hands & Feet	☐	☐
Urinary Problems	☐	☐

ENDOTHELIAL DYSFUNCTION (ENDOD)		
Angina (severe chest pain, often spreading to shoulder, arm, back, neck, or jaw)	☐	☐
Chest Pain that goes away with rest	☐	☐
Heartburn	☐	☐
Pain In Calves	☐	☐
Shortness of Breath	☐	☐
Stroke	☐	☐
TIA (mini stroke)	☐	☐

CARDIOMETABOLIC RISK (CMR)		
Headaches	☐	☐
Dizziness	☐	☐
Swelling of Ankles	☐	☐

INSULIN RESISTANCE (IR)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Fatigue (Tiredness)	☐	☐
Increased Hunger	☐	☐

SMALL FIBER SENSORY NEUROPATHY (SFN)		
Burning Sensations	☐	☐
Painful Contact With Socks or Bed Sheets	☐	☐
Pebble or Sandlike Sensation in Shoes	☐	☐
Stabbing or Electrical Shock Sensation	☐	☐
Pins And Needles Sensation In Feet	☐	☐

CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)		
Blurred Vision	☐	☐
Cold, Clammy, Pale Skin	☐	☐
Depression	☐	☐
Dizziness or Lightheadedness	☐	☐
Thirst	☐	☐
Fainting	☐	☐
Fatigue (Tiredness)	☐	☐
Lack of Concentration	☐	☐
Lack of Energy	☐	☐
Nausea	☐	☐
Rapid, Shallow Breathing	☐	☐

PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)		
Blood clot in a vein (Venous Thrombosis)	☐	☐
Heart Attack	☐	☐
Irregular heartbeat, too fast/slow (Atrial Fibrillation)	☐	☐
Stroke	☐	☐

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REGISTRATION FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single ❑ Mar ❑ Div ❑ Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

INSURANCE INFORMATION

(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.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ Aetna ❑ Medicaid ❑ BlueCross ❑ Other _____

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 Paces Ferry Medical Group, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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HEALTH HISTORY QUESTIONNAIRE

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Name *(Last, First, M.I.):* ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: **Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:

☐ Tetanus ☐ Pneumonia
☐ Hepatitis ☐ Chickenpox
☐ Influenza ☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

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- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting?			☐ Yes	☐ No
If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
# of meals you eat in an average day?				
Rank salt intake	☐ Hi	☐ Med	☐ Low	
Rank fat intake	☐ Hi	☐ Med	☐ Low	

Caffeine

☐ None	☐ Coffee	☐ Tea	☐ Cola

# of cups/cans per day?

Alcohol

Do you drink alcohol?	☐ Yes	☐ No
If yes, what kind?		
How many drinks per week?		
Are you concerned about the amount you drink?	☐ Yes	☐ No
Have you considered stopping?	☐ Yes	☐ No
Have you ever experienced blackouts?	☐ Yes	☐ No
Are you prone to "binge" drinking?	☐ Yes	☐ No
Do you drive after drinking?	☐ Yes	☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day

☐ # of years ☐ Or year quit

Drugs

Do you currently use recreational or street drugs?	☐ Yes	☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No

Sex

Are you sexually active?	☐ Yes	☐ No
If yes, are you trying for a pregnancy?	☐ Yes	☐ No
If not trying for a pregnancy list contraceptive or barrier method used:		
Any discomfort with intercourse?	☐ Yes	☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety

Do you live alone?	☐ Yes	☐ No
Do you have frequent falls?	☐ Yes	☐ No
Do you have vision or hearing loss?	☐ Yes	☐ No
Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
Would you like information on the preparation of these?	☐ Yes	☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Date of last pap and rectal exam?

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Paces Ferry Medical Group, P.C.
3193 Howell Mill, Suite 223
Atlanta, Georgia 30327
404.351.5262

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives a patient the right to request all uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This information will remain in effect until revoked in writing

I wish to be contacted in the following manner. (Check all that apply):

- ☐ Cell phone _____
- ☐ Home Phone _____
- ☐ Okay to leave message with detailed information
- ☐ Leave name/doctor with call back number only
- ☐ Work telephone _____
- ☐ Leave detailed message on work voicemail
- ☐ Leave message with name/doctor and call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address
- ☐ Other _____
- ☐ Email _____

_____

Patient signature Date

_____

Print name Birthdate

Healthcare providers must keep records of PHI disclosures. Information provided will be documented on the test results, progress notes, or patient communication in question.

PACES FERRY MEDICAL GROUP WELLNESS

Your name: _____

Today's date: _____

Your date of birth: _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? _____

2. Are you a female or a male?

☐ Male. ☐ Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Quality of Life Questionnaire

Date: _____

Patient's Name: _____ DOB: _____

Patient's Phone Number: _____ Email: _____

1, Have you ever been diagnosed with Allergies? YES ☐ NO ☐ _____

2. Are you currently taking or have you within the last year taken or have been prescribed any over-the-counter or prescription strength medications for allergies, hay fever, or nasal congestion? YES ☐ NO ☐ _____

If YES, please list all that apply:

_____

_____

3. Have you ever been diagnosed with asthma? YES ☐ NO ☐ _____

4. Is your doctor currently treating your asthma with medications? YES ☐ NO ☐ _____

If YES, please list all that apply:

_____

_____

5. Please note that in the case of seasonal allergies, you may not be experiencing the following symptoms now, but may experience them regularly during a different season of the year.

Please check all that apply:

☐ Stuffy Nose	☐ Sore Throat	☐ Bad Breath
☐ Runny Nose	☐ Cough	☐ Snoring
☐ Nasal Congestion	☐ Post Nasal Drip	☐ Mouth Breathing
☐ Itchy Eyes	☐ Headaches	☐ Nose Bleeding
☐ Watery Eyes	☐ Trouble Sleeping	☐ Sinus Pain
☐ Itchy Throat	☐ Fatigue	☐ Loss of Taste/Smell

Patient Name _____

Date of Birth _____ Today's Date _____

Please check the appropriate box if you are currently experiencing any of these symptoms, and/or if you have experienced them in the last 7 to 14 days.

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Frequent Urination	☐	☐
Fatigue (Tiredness)	☐	☐
Heartburn	☐	☐
Increased Hunger	☐	☐
Nausea	☐	☐
Numbness & Tingling in Hands or Feet	☐	☐
Vomiting	☐	☐

SUDOMOTOR DYSFUNCTION (SUDOD)		
Burning Sensation	☐	☐
Difficulty Digesting Food	☐	☐
Dizziness or Fainting	☐	☐
Exercise Intolerance	☐	☐
Sexual Difficulties	☐	☐
Sweat Abnormalities	☐	☐
Tingling Hands & Feet	☐	☐
Urinary Problems	☐	☐

ENDOTHELIAL DYSFUNCTION (ENDOD)		
Angina (severe chest pain, often spreading to shoulder, arm, back, neck, or jaw)	☐	☐
Chest Pain that goes away with rest	☐	☐
Heartburn	☐	☐
Pain In Calves	☐	☐
Shortness of Breath	☐	☐
Stroke	☐	☐
TIA (mini stroke)	☐	☐

CARDIOMETABOLIC RISK (CMR)		
Headaches	☐	☐
Dizziness	☐	☐
Swelling of Ankles	☐	☐

INSULIN RESISTANCE (IR)	Today	7-14 Days
Blurred Vision	☐	☐
Elevated Blood Sugar	☐	☐
Extreme Thirst	☐	☐
Fatigue (Tiredness)	☐	☐
Increased Hunger	☐	☐

SMALL FIBER SENSORY NEUROPATHY (SFN)		
Burning Sensations	☐	☐
Painful Contact With Socks or Bed Sheets	☐	☐
Pebble or Sandlike Sensation In Shoes	☐	☐
Stabbing or Electrical Shock Sensation	☐	☐
Pins And Needles Sensation in Feet	☐	☐

CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)		
Blurred Vision	☐	☐
Cold, Clammy, Pale Skin	☐	☐
Depression	☐	☐
Dizziness or Lightheadedness	☐	☐
Thirst	☐	☐
Fainting	☐	☐
Fatigue (Tiredness)	☐	☐
Lack of Concentration	☐	☐
Lack of Energy	☐	☐
Nausea	☐	☐
Rapid, Shallow Breathing	☐	☐

PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)		
Blood clot in a vein (Venous Thrombosis)	☐	☐
Heart Attack	☐	☐
Irregular heartbeat, too fast/slow (Atrial Fibrillation)	☐	☐
Stroke	☐	☐

PACES FERRY MEDICAL GROUP, P.C.
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Telephone: (404) 351-5262 FAX: (404) 350-8873

MOTOR VEHICLE ACCIDENT AND/OR WORKERS COMPENSATION INSURANCE INFORMATION

PATIENT NAME: _____ _____ _____
FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER: ___/___/___ DATE OF BIRTH: _____

IS YOUR VISIT RELATED TO: A) Workers Comp Injury? YES ( ) NO ( )
B) Motor Vehicle Accident? YES ( ) NO ( )

A) IF YOUR VISIT IS RELATED TO A WORKERS COMP INJURY, PLEASE COMPLETE THE FOLLOWING:

Whom Were You Referred By: _____
NAME OF COMPANY

Company Contact Person: _____

Telephone Number: _____

Case Number: _____

SEND MEDICAL BILLS TO: _____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

B) IF YOUR VISIT IS RELATED TO A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

Whom Were You Referred By: _____
NAME OF ATTORNEY, RELATIVE, OR PHYSICIAN

INSURANCE ADJUSTER NAME _____

Telephone Number: _____

Claim Number: _____

Car Insurance Company: _____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

DO YOU HAVE PERSONAL MEDICAL INSURANCE? YES ( ) NO ( )

MV-9D (rev. 1-2013)
motor.etax.dor.ga.gov

Disabled Person's Parking Affidavit

☐ New ☐ Renewal

Section One - Except for signature(s), this form must be typed, electronically completed and printed or legibly hand printed.
Note: The vehicle owner information is only required when applying for a DP license plate. You do not have to own a vehicle to obtain a DP parking permit (placard). Apply at the Tag Office in the county in Georgia where you reside.

* Vehicle Owner's Full Legal Name	* Driver's License # & Name of Issuing State (person operating vehicle)
*Vehicle Owner's Street Address including city, state & zip	*County of Residence
Disabled Person's Full Legal Name	*Relationship to Vehicle Owner- Check only one box ☐ Child ☐ Self ☐ Spouse ☐ Ward
	* Disabled Person's Driver's License # & Name of Issuing State(if applicable)
Disabled Person's Street Address including City, State & ZIP	Active Military Duty ☐ Retired GA Veteran ☐

Section Two - For Institutions Only: This vehicle is used primarily for the transportation of disabled persons.

Institution's Full Legal Name (Institution as defined by Georgia Law §31-7-1)- Attach a copy of institutional license

Vehicle Year & Make	Vehicle Identification #	Vehicle Color	Vehicle Tag #

Institution Authorized Representative's Signature & Position –'PARKING PERMITS (Placards) ONLY' | Date

Section Three

Check applicable box(s) below: You may apply for both a Disabled Person's Parking Permit and Disabled Person's License Plate with this form.

☐ Temporary Parking Permit (Placard) No Fee-Termination date of disability: _____

☐ Permanent Parking Permit (Placard) No Fee- Must be replaced every four (4) years from issue date.

☐ Special Permanent Parking Permit (Placard) No Fee-Because of a physical disability, drives a motor vehicle which has been equipped with hand controls for the operation of the vehicle's brakes and accelerator; or is physically disabled due to the loss of, or loss of use of, both upper extremities. Must be replaced every four (4) years from issue date.

☐ Disabled Person's License Plate (Fee $20.00 plus any taxes that may be due).

Section Four - To be completed by a licensed doctor of medicine, osteopathic medicine, podiatrist, optometrist or a licensed chiropractor.

Is disability permanent? ☐ Yes ☐ No-Temporary permits shall be issued for no more than 180 days

I hereby swear and affirm that the above individual as defined by Georgia Law §24-9-101 and §460-6-221(5):

☐ Is so ambulatory disabled that he/she cannot walk 200 feet without stopping to rest.

☐ Cannot walk without use of assistance from a brace, a cane, a crutch, another person, a prosthetic device, a wheelchair, or other assistive device.

☐ Is restricted by lung disease to such an extent that his/her forced respiratory volume for one second, when measured by spironmetry is less than one liter, or when at rest his/her arterial oxygen tension is less than 60 millimeters of mercury on room air.

☐ Uses portable oxygen.

☐ Has a cardiac condition to the extent that his/her functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ Is severely limited in his/her ability to walk due to an arthritic, neurological, orthopedic condition or complications due to pregnancy.

☐ Is hearing impaired pursuant to Georgia Law §24-9-101.

☐ Is blind individual whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity, if better than 20/200, is accompanied by a limit to the field or vision in the better eye to such degree that is widest diameter subtends and angle of no greater than twenty-degrees(20).

Section Five - Certification

Licensed Doctor's Printed Name	Doctor's License #	State of Issuance	Signature
TIMOTHY A. YOUNG, MD	25076	GA	

Office Street Address including City, State & ZIP	Telephone # including area code
3193 HOWELL MILL ROAD, SUITE 223, ATLANTA, GEORGIA 30327	(404) 351-5262

Note: Notarization Required For Licensed Doctor's Signature

Sworn to and subscribed before me	Notary Public's Signature & Notary Seal or Stamp
This _____ day of _____, _____ (Day) (Month) (Year)	Date My Notary Commission Expires

County and State Use Only

* Retention Schedule: This form will be retained at the County Tag Office for two (2) years from the date issued.

Disabled Person's Parking Permit # _____

PACES FERRY MEDICAL GROUP
3193 Howell Mill Road Ste 223
Atlanta, Georgia 30327

Telephone: (404) 351-5262

FAX: (404) 350-8873

Request for an Individual's Health Information

Last: **First:** **Middle:**

Other Names Used: **Date of Birth:** **SS#:**

Address:

Home Phone: ( ) **Work Phone: ( )**

☐ I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the following providers associated with the Paces Ferry Medical Group listed below.

[ ] Most recent Progress Note
[ ] Pathology/Lab Reports
[ ] X-rays Reports
[ ] Billing Records
[ ] Immunization Records
[ ] Entire Health Record
[ ] Other_____

[ ] I will pick up the copies of my records
[ ] Mail copies of my records to the individual noted below :

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, PFMG Physicians and/or PFMG Children's Physicians may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules. The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____

Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date

PFMG

Paces Ferry Medical Group, P.C.

3193 Howell Mill Road, Suite 223
Atlanta, Georgia 30327

OPIOID DEPENDENCY

SEVERITY QUESTIONNAIRE

Patient's Name: _____

Within the last 12 months:

1. Have you taken opioids in a larger amount or over a longer period of time than was intended?
   Yes / No
2. Was there a persistent desire or unsuccessful efforts to cut down or control opioid use?
   Yes / No
3. Was there a great deal of time spent in activities necessary to obtain the opioid, use the opioid or recover from its effects?
   Yes / No
4. Was there a craving or a strong desire or urge to use opioids?
   Yes / No
5. Did recurrent opioid use result in a failure to fulfill major responsibilities at work, school or home?
   Yes / No
6. Was there continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids?
   Yes / No
7. Were important social, occupational or recreational activities given up or reduced because of opioid use?
   Yes / No
8. Did recurrent opioid use occur in situations in which it was physically hazardous?
   Yes / No
9. Did continued opioid use occur despite knowledge of having a persistent or recurrent physical or psychological problem that was likely to have been caused or exacerbated by the substance?
   Yes / No
10. Did tolerance occur?
    Yes / No
11. Were withdrawal symptoms experienced and were opioids take to relieve or avoid the symptoms?
    Yes / No

_____ _____

Physician Signature Date

PACES FERRY MEDICAL GROUP, P.C.

Patient Name: _____ **DOS:** _____

Medical Records: _____

CONSENT TO PARTICIPATE IN BUPRENORPHINE (SUBOXONE OR SUBUTEX)

I hereby authorize and give voluntary consent to Paces Ferry Medical Group, P.C. and its medical personnel to administer and/or dispense or administer Opioid pharmacotherapy (**buprenorphine**), as part of the treatment of my addition to Opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed Opioid drug at the schedule, determined by the program physician, in accordance with Federal and State regulations.

It is explained to me that, like all other prescriptions, Opioid treatment medications can be harmful if not taken as prescribed. I further understand that Opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risk and benefits have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me for any other problem, that I am enrolled in an Opioid treatment program. This is so that the provider can provide the best possible care and can avoid prescribing medications that might affect my Opioid pharmacotherapy or my chances for successful recovery from addiction.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of medications prescribed at any time. Should I choose this option; I understand that I will be offered a medically supervised tapering.

For female patients of childbearing age: If I become pregnant, I understand that I should inform the Medical Assistant at Paces Ferry Medical Group, P.C. right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in Opioid pharmacotherapy.

_____ Date: _____

Patient Signature

_____ Date: _____

Witness Name Witness Signature

PACES FERRY MEDICAL GROUP, P.C.

PREGNANCY TEST WAIVER FORM

As a routine part of admission, annual physical and testing, all women of childbearing age are asked about their pregnancy status. Women who deny pregnancy will be asked to sign a pregnancy waiver (see below). If unsure, a urine pregnancy test will be offered to you. This test is painless and only takes a few minutes. As there are risk to Suboxone/Subutex, the benefits to potential mother and baby are enormous. All patients, however, for reason of privacy or otherwise, may refuse to have this urine pregnancy test preformed. Our goal is to provide the safest, high quality of medical care. If you have any questions, please consult your physician.

I, _____ certify that the risk of Suboxone/Subutex while pregnant has been explained to me, and I am not pregnant. If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test an I declined. I hereby release Paces Ferry Medical Group, P.C. of any liability if I am indeed pregnant at the time of treatment.

_____

Patient Signature

_____

Witness

_____

Date