

Paces Ferry Medical Group, P.C. 3193 Howell Mill, Suite 223

3193 Howell Mill, Suite 223 Atlanta, Georgia 30327 404.351.5262

PATIENT UPDATE FORM

(Piease Print) PCP:

PATIENT INFORMATION

Patient's last name:	first:	Middle:	🗆 Mr.	🗅 Miss	Marit	al status (circle	one)
: •			O Mrs.	G Ms.		e / Mar / Div	
Is this your legal name? If not,	, what is your legal name?	(Former name):	Birti	n date:	Age:	Sex:
🗆 Yes 🗆 No		, , ;			1	/	OM OF
Street address:		Social Sec	urity na.:		Home	phone no.:	
•			,		/	> prione no	
P.O. box:	City:		State:) ZIP Code:	
			i.				
Occupation:	Employer:				Emplo	yer phone no.:	
	1				()	
	INSURAN	CE INFORM	ATION				
	(Please give your ins	urance card to t	he receptioni:	st.)			
Person responsible for bill: Bir	th date: Address (if diff			· · · ·			
	/ / / .	nerent/.			Home	phone no.:	
Is this person a patient here?	Yes 🗘 No		····· .		· ()	
Occupation: Employer:	Employer address:	1997 - 19					
······································					Employ	yer phone no.:	
Is this patient covered by insurance?	🖙 Yes 🖾 No	• •• • • • •			()	
Please indicate primary insurance	🖸 Medicare 🖸 Aetna 🗔 N	4edicaid 🗆 Bi	ueCross 🖸	Other			
Subscriber's name:		rth date:	Group no.:		Policy	ào •	Co-payment:
		1 1	•				e poyment.
Patient's relationship to subscriber:	G Self G Spouse	D Child	Other				₽
Name of secondary insurance (if ap	plicable): Subscriber's name			Group n	ю.:	Policy	no.:
Patient's relationship to subscriber:	🗆 Self 🗘 Spouse	🗅 Child	Other				
	IN CASE	OF EMERGI					
Name of local friend or relative (not		Relationship to		More ei		. Manula _k_	
,			- pariona	/ /	none no.;	: Work pho	ne no,:
The above information is true to the that I am financially responsible for information required to process my o		orize my insuran aces Ferry Medic	e benefits be al Group, P.C	e paid dire	ctly to th ance com	() e physician. I (pany to releas	understand e any

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.

Marital statu	st, M.I.):		100 100 0000 100 101 11 1 10 1 1 1 1	<u>о</u> моғ ров:	
	i s: 🗆 Single	e 🗋 Partnered	Married Separated	Divorced D Widowed	
Previous or r	eferring do	ctor:		Date of last physical exam:	
			PERSONAL HEA	LTH HISTORY	
Childhood illi		Measles 🗖 Mum	ns (1) Rubella 🗆 Chickenne	x 🗀 Rheumatic Fever 🗔 Pollo	
Immunizatio		🗇 Tetanus			
dates:		C Hepatitis			
		🗆 Influenza		MMR Massles, Mumps, Rubella	
List any medi		••••••			
		1.2 COLLE VIIIII VIII	tors have diagnosed		
Surgeries					
fear F	Reason			Hospital	
······				Тоэрка	
Other hospita	lizations				
′еаг Я	1				
rour r	leason			Hospitai	
r Gar e	season			flospitai	
				, Hospital	
		······································		, tiospital	
		······	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	
	· · · · · · · · · · · · · · · · · · ·		ounter drugs, such as vita:	nins and inhalers	
lst your pres	cribed drug		ounter drugs, such as vita:	nins and Inhalers	
ist your pres	cribed drug	s and over-the-c		nins and inhalers	
ist your pres	cribed drug	s and over-the-c	ounter drugs, such as vita: Strength	nins and Inhalers	
lst your pres	cribed drug	s and over-the-c	ounter drugs, such as vita: Strength	nins and Inhalers	
ist your pres	cribed drug	s and over-the-c	ounter drugs, such as vita: Strength	nins and Inhalers Frequency Taken	
.ist your pres lame the Drug	cribed drug	s and over-the-o	ounter drugs, such as vita: Strength	nins and Inhalers	
.ist your pres lame the Drug .liergies to m	cribed drug edications	s and over-the-o	ounter drugs, such as vita: Strength	nins and Inhalers Frequency Taken	
List your pres Name the Drug	cribed drug edications	s and over-the-c	ounter drugs, such as vita: Strength	nins and Inhalers Frequency Taken	
.ist your pres Name the Drug	cribed drug edications	s and over-the-c	Strength	nins and Inhalers Frequency Taken	
List your pres Name the Drug	cribed drug edications	s and over-the-c	ounter drugs, such as vita: Strength	nins and Inhalers Frequency Taken	

ONAI CACETY HEALTH HABITS AND PERSONAL SAFETY

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	ALL QUESTIONS CONTA	INED IN THIS QUESTIO	NNAIRE ARE OPTIONAL AN	D WILL BE KEPT STRICTLY CONFIL	DENTI	AL.						
Exercise	🗇 Sedentary (No exe	ercise)		10 1 0 0 1 1 0 1000 0001 001100 0 1000 100 10 1								
	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?	Ð	Yes		No							
	If yes, are you on a p	: 🛱	Yes	Þ	No							
	# of meals you eat in	n an average day?										
	Rank salt intake	CI HI	🗆 Med	🗆 Low								
	Rank fat intake	C) HI	□ Med									
Caffeine	None	🗆 Coffee	🖸 Tea	C) Cola								
	# of cups/cans per d	ay?										
Alcohol	Do you drink alcohol?	?				Yes	្ពា	No				
	If yes, what kind?											
	How many drinks per	week?										
	Are you concerned at		Yes	ĺΩ	No							
	Have you considered	D	Yes		No							
	Have you ever experi	enced blackouts?				Yeş	l 🗅	No				
	Are you prone to "bin	ge" drinking?				Yes		No				
	Do you drive after drinking?							No				
Tobacco	Do you use tobacco?					Yes		No				
	🗋 Cigarettes – pks./day 🔲 Chew - #/day 🔲 Pipe - #/day 💭											
	🖾 # of years											
Drugs	Do you currently use	recreational or street dru	ıgs?		· 💭	Yes	0	No				
	Have you ever given y	yourself street drugs wit	h a needle?			Yes		No				
Sex	Are you sexually activ	e?			Ö	Yes		No				
	If yes, are you trying	۵	Yes	D	No							
	If not trying for a pres	gnancy list contraceptive	or barrier method used:									
	Any discomfort with in	ntercourse?			Þ	Yes		No				
	 problem. Risk factors 	Human Immunodeficiend for this illness include in your provider about you	travenous drug use and unp	, has become a major public health rotected sexual intercourse. Would	, 	Yes	D	No				
Personal	Do you live alone?					Yes		No				
Safety	Do you have frequent fails?							No				
	Do you have vision or		Yes	۵	No							
	Do you have an Advar	· 🗀	Yes		No							
	Would you like information on the preparation of these?							No				
	Physical and/or menta	l abuse have also becon areatening behavior or a	ne major public health issues	s in this country. This often takes se. Would you like to discuss this		Yes Yes		No				

FAMILY HEALTH HISTORY - --

	AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT I	HEAL	TH PR	OBLE	MS
Father			Children		M					

Mother										
Sibling										
	Ш М	· · · · · · · · · · · · · · · · · · ·					••••••			
			Grandmother		F					
	ā F		Maternal			:				
	С M С F	1	Grandfather Maternal							
	шM		Grandmother							
		· · · · · · · · · · · · · · · · · · · ·	Paternal							
			Grandfather Paternal							
		MENTA	L HEALTH					••••••		
Is stress a m	ajor problem for ye							Yes		No
Do you feel d	epressed?							Yes	D	No
Do you panic	when stressed?							Yes	Þ	No
Do you have	problems with eat	ing or your appetite?					α	Yes		No
Do you cry fr	equently?						Ē	Yes	D	No
Have you eve	r attempted suicid	·····						Yes		No
Have you eve	r seriously though	t about hurting yourself?						Yes	. 🗖	No
Do you have	trouble sleeping?							Yes	σ	No
Have you eve	r been to a counse	elor?						Yes		No
		· · · · · · · · · · · · · · · · · · ·							:	
		WOMI							-	
	of menstruation:									
Date of last n							•••			•••••••
Period every	······						•••••			
		tting, pain, or discharge?					. m	Yes	; _	No
		Number of live births						. 43	. 	110
	ant or breastfeed							Yes	0	No
							·†		÷	
								Yes		No
		dney infections within the last year?						Yes		
Any blood in y								Yes	÷	No
	with control of ur							Yes	۵	
	es or sweating at r						0	Yes	<u> </u>	No
Do you have	menstrual tension,	pain, bloating, irritability, or other sympto	oms at or around ti	me of	period?		. š	Yes	<u>.</u>	
Experienced a	iny recent breast t	enderness, lumps, or nipple discharge?						Yes		No
				· · · · • • • • • · · · · · ·						

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	MEN ONLY					
Do you usually get up to urinate during the night	?			Yes	. Ö	No
If yes, # of times						
Do you feel pain or burning with urination?			C	Yes		No
Any blood in your urine?			: 🛱	Yes	Ċ	No
Do you feel burning discharge from penis?				Yes	D	No
Has the force of your urination decreased?					Ð	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	D	No
Any difficulty with erection or ejaculation?			; D	Yes		No
Any testicle pain or swelling?				Yes		No
Date of last prostate and rectal exam?				Yes		No
· · · · · · · · · · · · · · · · · · ·	OTHER PROBLEM:					
Check if you have, or have had, any symptoms in	the following areas to a significant d	legree and briefly explain.				
🗅 Skin	C Chest/Heart	Recent changes in:				

SKIN	ш	Cnest/Heart		Recent changes in:	1
Head/Neck	Ш	Back	D	Weight	:
Ears	₽	Intestinal		Energy level	
Nose		Bladder		Ability to sleep	:
Throat	C	Bowel		Other pain/discomfort:	-
Lungs		Circulation			-
	Head/Neck Ears Nose Throat	Head/Neck Ears Nose Throat	Head/Neck Image: Back Ears Intestinal Nose Bladder Throat Bowel	Head/Neck I Back I Ears I Intestinal I Nose I Bladder I Throat I Bowel I	Head/Neck I Back Weight Ears Intestinal Energy level Nose Bladder Ability to sleep Throat Bowel Other pain/discomfort:



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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):

ell phone
ome Phone
kay to leave message with detailed information
eave name/doctor with call back number only
ork telephone
eave detailed message on work voicemail
 eave message with name/doctor and call back number only
'hen unable to contact me by phone, a written communication may be sent to my
 ome address
ther
mail

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	<u>.</u>

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. 🛛 Fernale.

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.

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

🗇 Very well; could hardly be better.

C 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.			0		
Trouble eating well,					
Teeth or denture problems.					
Problems using the telephone.					
Tiredness or fatigue.	IJ				

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.

Ses, 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.

 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.

C 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.

COther.

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

Quality of Life Questionnaire

					Da	te:
Pa	tient's Name:	DC)B:			
Pa	tient's Phone Number:		Email:			
	Have you ever been dia					
ha	Are you currently taking ve been prescribed any adications for allergies,	over-the	a-counter or prescription		or th	NO 🛱
if 1	/ES, please list all that a	+				
з.	Have you ever been dia		vith asthma?			NO 🖸
4,	is your doctor currently	treating	your asthma with medi	ications	YES 🖸	NO 🗖
lf Y	/ES, please list all that a					· · • •••••••••
syr	Please note that in the o nptoms now, but may e ase check all that apply	case of so experience	easonai allergies, you m ce them regularly during	ay not b	e experienci	ing the following
0	Stuffy Nose	a	Sore Throat		Bad Breath	
a	Runny Nose		Cough	-	Snoring	•
5	Noral Concertion	-				

Nesal Congestion

Itchy Eyes

,

- C Watery Eyes
- 🚨 ltchy Throat
- Post Nasal Drip
- 🚨 Headaches
- C Trouble Sleeping
- 🖓 Fatigue

Mouth Breathing

-

- Nose Bleeding
- Sinus Pain
- Loss of Taste/Smeli

Pint Hais

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.

		7-14			
AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	Today	Days	INSULIN RESISTANCE (IR)	Today	7-14 Days
Blurred Vision	_		Blurred Vision		_
Elevated Blood Sugar			Elevated Blood Sugar		
Extreme Thirst		Ð	Extreme Thirst	ā	Ö
	Ē		Faligue (Tiredness)	· a	0
Frequent Urination			Increased Hunger		
Faligue (Tiredness)	Ľ.)			····	ب مى
Heartburn			SMALL FIBER SENSORY NEUROPATHY (S	FN)	
Increased Hunger			Burning Sensations	Ö	
Nausea	D	C	Painful Contact With Socks or Bed Sheets	0	
Numbness & Tingling in Hands or Feet			Pebble or Sandlike Sensation in Shees	a	0
Vomíting			Stabbing or Electrical Shock Sensation	0	Đ
SUDOMOTOR DYSFUNCTION (SUDOD)			Pins And Needles Sensation In Feet		0
Burning Sensation		0			
Difficulty Digesting Food		D	CARDIOMETABOLIC AUTONOMIC NEUROF	PATHY (C.	AN)
Dizziness or Fainling	Ľ		Blurred Vision	C3	
Exercise Intolerance		D	Cold, Clammy, Pale Skin		\Box
Sexual Difficulties	Ö		Depression		
Sweal Abnormalilies			Dizziness or Lightheadedness		
Tingling Hands & Feet			Thirst		
Urinary Problems	0		Fainting	Ē	
	<u>لبا</u>		Faligue (Tiredness)		
ENDOTHELIAL DYSFUNCTION (ENDOD)		•	Lack of Concentration		
Angina (severe chest pain, often spreading			Lack of Energy		
to shoulder, arm, back, neck, or jaw)	C	Ω	Nausea		
Chest Pain that goes away with rest	Ω	0	Rapid, Shallow Breathing	CT .	Ċ
Heartburn	CI			-	<u> </u>
Pain In Calves	Ū		PLETHYSMOGRAPHY CARDIOVASCULAR		
Shortness of Breath			DISEASE (PTG CVD)		
Stroke		ū	Blood clot in a vein (Venous Thrombosis)		£.)
TIA (mini stroke)	Ē		Hearl Atlack	\Box	5
	- 1010 - 1010	;	Irregular heartbeat, too fast/slow (Atrial Fibrillation)	, 🗖	
CARDIOMETABOLIC RISK (CMR)			Stroke		D
Headaches		D	· · · · · · · · · · · · · · · · · · ·		
Dizziness	Ē	Ð			
Swelling of Ankles	n				



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REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

PCP:

Patient's last name:	Fir	st:	Middle:	C) Mr. C) Mrs.	🗅 Miss 🗔 Ms.		tatus (circle Mar 🖨 Div		7
Is this your legal name?	If not, what is your le	gai name?	(Former name	e):	Birth	date:	Age:	Sex:	
🖸 Yes 🖾 No						1 1		ШM	Ċ F
Street address:			Social Se	curity no.:		Home ph	one no.:		
						()			
P.O. box:	City:			State	5	Z	P Code:		
Occupation:	Employer:					Employer	phone no.	 :	
						())		
		INSURA	NCE INFORI	MATION					
	(Plea	se give your	insurance card to	the reception	list.)				
Person responsible for bill:	Birth date:	Address (if	different):			Home ph	one no.:	· · · · · · · · · · · · · · · · · · ·	·····.
	1 1		·			()			
Is this person a patient here	e? 🖾 Yes 🗔 No								
Occupation: Employ	yer: Employe	er address:				Employer	phone no.	;	
						()			
Is this patient covered by insurance?	Ci Yes C	No				·			
Please indicate primary insu	rance 🖸 Medicare	🗅 Aetna 🛛	🗅 Medicaid 🛛 🔾	BlueCross (Gother			·····	
Subscriber's name:	Subscriber's S	5.S. no.:	Birth date:	Group no.:	:	Policy no.	:	Co-payr	nent:
								\$	
Patient's relationship to sub	scriber: 🔾 Self	🛱 Spou	se 🛛 Child	O Other					
Name of secondary insurand	ce (if applicable): S	ubscriber's na	ame:		Group (no.:	Polic	y no.:	
Patient's relationship to sub	scriber: 🗀 Self	C Spou	se 🖸 Child	🗅 Other					
		IN CAS	E OF EMERC	SENCY					
Name of local friend or relat	tive (not living at same	address):	Relationship	to patient:	Home p	hone no.:	Work ph	ione no.:	
					()	()	
The above information is tru that I am financially response information required to proc	sible for any balance. I	nowiedge. I a also authoriz	uthorize my insura te Paces Ferry Me	ance benefits dical Group, I	be paid din P.C. or insur	ectly to the ance comp	physician. any to relea	l understa ise any	and
Patient/Guardian signatu	re				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 Pair, ML)F DOB: Marital status: Single Partnered Marited Separated Divorced Widowed Previous or referring doctor: Data of last physical exam: PERSONAL HEALTH HISTORY PERSONAL HEALTH HISTORY Childhood Illness: Measles Measles Measles One One Childhood Illness: Measles Measles One children One One Childhood Illness: Measles Measles One children One One One Childhood Illness: Measles Measles One children One One Childhood Illness: Measles Measles One One One One One Childhood Illness: Measles Measles One One One One Childhood Illness: Measles One One One One One One Let any medical problems that other doctors have diagnosed Surgeries Ever Reason Hospital Ist your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers ame the Drug Strength Frequency Taken Hergies to medications ame the Drug Reaction You Had								
Previous or referring doctor: Date of last physical exam: PERSONAL HEALTH HISTORY Childhood illness: Measles Mumps Rubella Chickenpox Resumatic Fever Pollo Childhood illness: Heasles Mumps Rubella Chickenpox Ribed Childhood illness: Heasles Mumps Rubella Chickenpox Ribed Childhood illness: Heasles Mumps Rubella Chickenpox Rubella Chickenpox I Influenza I Mill Adades Adams, Rubella Surgeries Surgeries Strength Hospital Sterngth Frequency Taken Hespies to medications	lame (Last, Fil	st, M.I.):			⊡ M	ΰÞ	DOB:	
PERSONAL HEALTH HISTORY Childhood Itiness: G Measles Immunizations and lates: G Tetanus I repatitis G Chickenpox I Influenza MMR Masking Monpus, Fulloots List any medical problems that other doctors have diagnosed MMR Masking Monpus, Fulloots Strengeries Hospital tear Reason Her hospitalizations Hospital Strength Frequency Taken Ist your prescribed drugs and over-the-counter drugs, such as vitamines and Inhalers ame the Drug Strength Frequency Taken	larital statu	is: 🗆 Single	: 🗆 Partnered	🛛 Married 🖾 Separated	Divorced D] Widowee	d	
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	ime the Drug	1		Strength		Fre	equency Taken	
						<u></u>		
ame the Drug Reaction You Had					····· · ·			
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			· · · · · · · · · · · · · · · · · · ·	Reaction You Had			· · · · · · · · · · · · · · · · · · ·	

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HEALTH HABITS AND PERSONAL SAFETY

£	ALL QUESTIONS CONTA	INED IN THIS QUESTIC	NNAIRE ARE OPTIONAL AND	WILL BE KEPT STRICTLY CONF	DENTI	AL.			
Exercise	Sedentary (No exe								
	🖾 Mild exercise (i.e.,	climb stairs, walk 3 blo	cks, golf)				• •		
	Occasional vigorou	us exercise (i.e., work of	r recreation, less than 4x/wee	ek for 30 min.)					••••
	🗆 Regular vigorous d	exercise (i.e., work or re	creation 4x/week for 30 minu	ites)					
Diet	Are you dieting?					Yes		No	
	If yes, are you on a (physician prescribed me	dical diet?		D	Yes		No	
	# of meals you eat in	n an average day?			'				
	Rank salt intake	C) Hi	🗂 Med	: 🖸 Low					
	Rank fat intake	ШHI	🖸 Med	Low					
Caffeine	None	C Coffee	🖾 Tea	🗆 Cola					
	# of cups/cans per d	ay?							
Alcohol	Do you drink alcoholi	2		·····	🗆	Yes		No	
	If yes, what kind?								· .
	How many drinks per	week?							
	Are you concerned at	out the amount you dri	nk?			Yes		No	
	Have you considered	stopping?				Yes		No	
	Have you ever experi	enced blackouts?			: 🖸	Yes		No	
	Are you prone to "bin	ge" drinking?			0	Yes	Ð	No	
	Do you drive after dri	inking?				Yes		No	
Tobacco	Do you use tobacco?				យ	Yes		No	
	🖾 Cigarettes – pks./	day	🖾 Chew - #/day	🖾 Pipe - #/day	🖽 Cig	ars - #	t/day		
	🖾 # of years	🖾 Or year quit							
Drugs	Do you currently use	recreational or street dr	ugs?		Ľ	Yes	̤	No	
	Have you ever given	yourself street drugs wit	h a needle?			Yes		No	
Sex	Are you sexually activ	re?				Yes		No	
	If yes, are you trying	for a pregnancy?			D	Yes	Þ	No	
	If not trying for a pre	gnancy list contraceptive	e or barrier method used:						
	Any discomfort with it					Yes	Ð	No	:
	problem. Risk factors	Human Immunodeficien for this illness include ir a your provider about yo	travenous drug use and unpr	has become a major public healt rotected sexual intercourse. Woul	d d	Yes		No	
Personal	Do you live alone?			NNT F		Yes	D	No	1
Safety	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?							No	
	Would you like inform	ation on the preparation	n of these?			Yes		No	۰÷
	Would you like information on the preparation of these? 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	D	No	

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	FAMILY HEA	LTH HISTORY					
	AGE SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HE	ALTH PR	OBLE	MS
Father		Children					
Mother							
Sibling	다 ~~ 다 F	,					
			C M C F				
	0 M	Grandmother					
		Maternal Grandfather					
		Maternal					
		Grandmother Paternal					
	. 🗆 M	Grandfather	· ·				
		Paternal					
	MENTAL	HEALTH					
Is stress a majo	r problem for you?				⊐ Yes		No
Do you feel dep	ressed?				∐ Yes		No
Do you panic wi	nen stressed?			() Yes	l 🗆	No
Do you have pro	oblems with eating or your appetite?				🗍 Yes		No
Do you cry frequ	uently?			Ĩ	∃ Yes		No
	Ittempted suicide?			t) Yes	Ø	No
	eriously thought about huiting yourself?				⊇ Yes		No
Do you have tro	The second s			1] Yes	ω	No
	peen to a counselor?			······ ··· · · · · · · · · · · · · · ·) Yes	D	No
						•	
	WOME	N ONLY					
			••••••	· · · · · · · · · · · · · · · · · · ·			
Age at onset of	menstruation:						
Date of last mer	nstruation:						
Period every	days						
Heavy periods, i	rregularity, spotting, pain, or discharge?			ε) Yes	C	No
Number of preg	nancies Number of live births				_		
Are you pregnar	it or breastfeeding?			Ē	🛛 Yes	ļ	No
Have you had a	D&C, hysterectomy, or Cesarean?			Ċ	∃ Yes		No
Any urinary trac	t, bladder, or kidney infections within the last year?			Ċ	J Yes	Ð	No
Any blood in you				ſ	J Yes		No
Any problems w	ith control of urination?			E	⊐ Yes	0	No
	or sweating at night?] Yes	Ð	No
	instrual tension, pain, bloating, irritability, or other symptom	ns at or around ti	me of period?	, c	3 Yes	Ξ	No
	recent breast tenderness, lumps, or nipple discharge?		,	: [Yes		No
	and rectal exam?						
· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·					•••••••	

MEN ONLY

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Do you usually get up to urinate during the night?	Ü	Yes		No
If yes, # of times				
Do you feel pain or burning with urination?	D	Yes		No
Any blood in your urine?		Yes	B	No
Do you feel burning discharge from penis?	: Ö	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	B	No
Any difficulty with erection or ejaculation?	C	Yes	D	No
Any testicle pain or swelling?	D	Yes		No
Date of last prostate and rectal exam?	0	Yes		No
OTHER PROBLEMS				

	Skin	₽	Chest/Heart	Recent changes in:
	Head/Neck		Back	Weight
	Ears		Intestinal	Energy level
	Nose	₽	Bladder	Ability to sleep
۵	Throat		Bowe!	Other pain/discomfort:
Ģ	Lungs		Circulation	



Paces Ferry Medical Group, P.C.

3193 Howell Mill, Suite 223 Atlanta, Georgía 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

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.

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.

Your name: _____ Today's date: _____

Your date of birth:

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.

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?

11⁻¹¹-11-11-1-1-1-1-1-1-1-1-1 -1-1-1-1-1-	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.					
Sexual problems.					
Trouble eating well.					Ü
Teeth or denture problems.					
Problems using the telephone.					
Tiredness or fatigue.		Û			

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.

D 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

	Da	te:	
Patient's Name:	DC	⊁B:	
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?		NO 🖾	
4. Is your doctor currently treating your asthma with medications?	YES 🕻	NO 🖸	
If YES, please list all that apply:	Hullin and a starter a		
5. Please note that in the case of seasonal allergies, you may not be e	xperienc	ing the following	*******

symptoms now, but may experience them regularly during a different season of the year.

Please check all that apply:

- Stuffy Nose
- C Runny Nose
- Nasal Congestion
- 🛄 ltchy Eyes
- Watery Eyes
- 🖬 🛛 İtchy Throat

- 🔾 Sore Throat
- Cough Cough
- Post Nasal Drip
- Headaches
- Trouble Sleeping
- C Snoring

G Bad Breath

- O Mouth Breathing
- Nose Bleeding
- 🔲 Sinus Pain
- 🛛 Fatigue
- Loss of Taste/Smell



Patient Name_

Date of Birth

. Today's Dale ----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 7-14 DYSFUNCTION (ANSD) Today INSULIN RESISTANCE (IR) Days 7-14 **Blurred Vision** Today Blurred Vision Days Elevated Blood Sugar Ο Elevated Blood Sugar Ê Ċ Extreme Thirst Ö Extreme Thirst \Box Frequent Urination D Faligue (Tiredness) Ο. Faligue (Tiredness) Ö D Increased Hunger Headburn D D \Box Increased Hunger Ö SMALL FIBER SENSORY NEUROPATHY (SFN) D Nausea **Burning Sensations** Numbriess & Tingling in Hands or Feet D Painful Contact With Socks or Bed Sheets Ö Ð D Vomiting Pebble or Sandlike Sensation in Shoes Ö Ö Ð Stabbing or Electrical Shock Sensation Ð SUDOMOTOR DYSFUNCTION (SUDOD) Pins And Needles Sonsation in Feet **Burning Sensation** \Box **Difficulty Digesting Food** \Box CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN) Dizziness or Fainling Blurred Vision Ö Exercise Intolerance Cold, Clammy, Pale Skin Sexual Difficulties D 0 Depression Sweat Abnormalilies Dizziness or Lightheadedness C Tingling Hands & Feel Ö Thirst Urinary Problems \Box Fainting D \Box Fáligue (Tiredness) ENDOTHELIAL DYSFUNCTION (ENDOD) \Box Lack of Concentration Angina (severe chest pain, often spreading Lack of Energy lo shoulder, arm, back, neck, or jaw) Chest Pain that goes away with rest Nausea O Rapid, Shallow Breathing Hearlburn \square Pain In Calves PLETHYSMOGRAPHY CARDIOVASCULAR O Shortness of Breath DISEASE (PTG CVD) Ü Slroke Blood clot in a vein (Venous Thrombosis) \Box TIA (mini stroke) \Box Hearl Allack Irregular heartbeái, too fasi/slow (Airial Fibrillation) 🛛 Ö. Ē CARDIOMETABOLIC RISK (CMR) \Box Stroke Headaches \Box Π Dizziness Swelling of Ankles ۵

PACES FERRY MEDICAL GROUP, P.C. 3193 Howell Mill Rd. Suite 223 Atlanta, GA 30327

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Q.

Telephone: (404) 351-5262	FA	X: (404) 350-8873	
MOTOR VEHICLE ACCIDENT	AND/OR WORKERS COMPENSATION INSUE	ANCE INFORMATION	•
PATTENT 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 LIGBURG COMP THE TIME DE DI CO		
Whom Were You Referred By:	A WORKERS COMP INJURY, PLEASE COM	PLETE THE FOLLOWING:	1
whom were rod kererred by:	NAME OF COMPANY		
Company Contact Person:		· · · · · · · · · · · · · · · · · · ·	
na stallen och som en sam skalen han en som en Marsen han en som en	Telephone Number:		
	Case Number:		
SEND MEDICAL BILLS TO:	NAME		
	ADDRESS		-
	CITY STATE		
IN A MARKET WAR AND		ZIP	
) IF YOUR VISIT IS RELATED TO	A MOTOR VEHICLE ACCIDENT, PLEASE	COMPLETE THE FOLLOWI	ENI
Whom Were You Referred By:			T
INSURANCE ADJUSTER NAME	NAME OF ATTORNEY, RELATIVE, OR I	PRISICIAN	Ť
	Telephone Number:		T
	Claim Number:		- 1
Car Insurance Company:			Ť
	NAMF.	un set an anna an a	T
	ADDRESS		†÷
	CITY STAT	E ZIP	+
DO YOU HAVE PERSONAL MEDICA	L INSURANCE? YES () NO ()		
"我们的人,我们就是一个人,我们就是一个人,我们就是一个人,我们就是一个人。" 我就说了,"你们,我们们们们们们,你们们们们们们们们们们们们们们们们们们们们们们们们们们			
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MV-9D (rev. 1-2013) motor.etax.dor.ge.gov

Disabled Person's Parking Affidavit

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 performance. * 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's License # & Name of Issuing State (if app Disabled Person's Street Address including City, State & ZIP Disabled Person's Street Address including City, State & ZIP Active Military Duty Retired GA Veteran Retired GA Veteran)
(placard). Apply at the Tag Office in the county in Georgia where you reside. * Vehicle Owner's Full Legal Name * Vehicle Owner's Street Address including city, state & zip * County of Residence Disabled Person's Full Legal Name * Disabled Person's Street Address including City, State & ZIP Active Military Duty Disabled Person's Street Address including City, State & ZIP)
Vehicle Owner's Full Legel Name Oriver's License # & Name of Issuing State (person operating vehicle Vehicle Owner's Street Address including city, state & zip County of Residence Oisabled Person's Full Legel Name Relationship to Vehicle Owner- Check only one box Oriver's License # & Name of Issuing State (person operating vehicle) *County of Residence *Relationship to Vehicle Owner- Check only one box Oriver's License # & Name of Issuing State (person operating vehicle) *Outy of Residence *Relationship to Vehicle Owner- Check only one box Oriver's License # & Name of Issuing State (person operating vehicle) Plisabled Person's Street Address including City, State & ZIP Active Military Duty Retired GA Veterson	
*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 Disabled Person's Full Legal Name *Relationship to Vehicle Owner- Check only one box Disabled Person's Full Legal Name *Relationship to Vehicle Owner- Check only one box Disabled Person's Full Legal Name *Oisabled Person's Driver's License # & Name of Issuing State(if app Disabled Person's Street Address including City, State & ZIP Active Military Duty Retired GA Veteran Disabled Person	
Disabled Person's Full Legal Name *Relationship to Vehicle Owner- Check only one box Disabled Person's Full Legal Name *Relationship to Vehicle Owner- Check only one box Disabled Person's Full Legal Name *Disabled Person's Driver's License # & Name of Issuing State(if app Disabled Person's Street Address including City, State & ZIP Active Military Duty Retired GA Veteran Disabled Person	
Disabled Person's Street Address including City, State & ZIP Active Military Duty Betired GA Veteran	
Disabled Person's Street Address including City, State & ZIP Active Military Duty Active Military Duty Retired GA Veteran	
Disabled Person's Street Address including City, State & ZIP Active Military Duty Retired GA Veteran	
Retired GA Veteran	cable
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	
Venice doioi	
Institution Authorized Representative's Signature & Position - PARKING PERMITS (Placards) ONLY'	
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 Territories data of the law	
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.	
C Special Permanent Perking Portalit (Pincerd) No Eas Parama of a charter in the second	
Special Permanent Parking Permit (Placard) No Fee-Because of a physical disability, drives a motor vehicle which has been equipped with hand control the operation of the vehicle's brakes and accelerator; or is physically disabled due to the loss of use of, both upper extremities. Must be replaced overy four (4) years from issue date.	s for aced
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, optimetrist or a licensed chiropractor.	
Is disability permanent? Yes No-Temporary permits shall be issued for no more than 160 days	
I hereby swear and affirm that the above individual as defined by Georgia Law §24-9-101 and §460-6-221(5):	<u></u>
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 liture when at rest his/her arterial oxygen tension is less than 60 millimeters of mercury on room air.	r, or
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 appage in the better even in the second appage.	in
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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) to (date)		
[] Most recent Progress Note	[] Immunization Records	
[] Pathology/Lab Reports	[] Entire Health Record	
[] X-rays Reports	[] Other	
[] Billing Records		

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:

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

Purpose of Request: ___patient's request, ___dispute, ___referral, ___other: ____

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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

- 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

- 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:
	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

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Date