Randy E. Durbin, D.O., P.C.
5400 Laurel Springs Pkwy, Suite 1404
Suwannee, GA 30024
PHONE: 706-216-7188 FAX: 855-884-2774

Primary Care Patient Information Sheet

Today's Date: _____/_____/_____ Patient Name (print): _____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female Social Security: _____

Address: _____ City, State, Zip: _____

E-mail: _____ Permission to contact via email? □ Yes □ No

Home Phone (_____) _____ Permission to leave message? □ Yes □ No

Cell Phone (_____) _____ Permission to leave message? □ Yes □ No

Work Phone (_____) _____ Ext: _____ Permission to leave message? □ Yes □ No

Patient Security Word* for phone calls: _____ (e.g. favorite car, pet's name, etc.)

Primary Care Doctor/Clinic: _____ Phone: _____

Address: _____ City, State, Zip: _____

Emergency Contact (Or Parent/Legal Guardian):

Last Name: _____ First Name: _____ MI: _____

Relationship: _____

Address: _____ City, State, Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext: _____

Permission to Leave Message with Emergency Contact: Home: □ Yes □ No Work: □ Yes □ No

Additional (secondary) Emergency Contact (Or Parent/Legal Guardian):

Last Name: _____ First Name: _____ MI: _____

Relationship: _____ Home Phone (_____) _____

Address: _____ City, State, Zip: _____

Permission to Leave Message with Emergency Contact: Home: □ Yes □ No

**Patient Security Word is used to verify identity when there is a verbal release of patient's Protected Health Information over the phone.*

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Social History:

Section A. If patient is an adult, please fill out the following. If a child, please skip to Section B:

Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian □ Other □ Declined

Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino □ Declined

Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated □ Domestic Partnered

Number of Children: _____ Their Year(s) of Birth: _____

Religious Affiliation: _____

Current Employment Status: □ Employed □ Unemployed □ Disabled □ Retired □ Student

Occupation and Responsibilities: _____

Place of Employment: _____

Hours Per Week: □ 0-10 □ 10-20 □ 20-30 □ 30-40 □ 40+

Hobbies/Recreation (Sports, Music/Arts, Crafts):_____

Please select smoking status: □ Current (daily) □ Current (some days) □ Former □ Never

□ Smoker, current status unknown □ Unknown if ever smoked

If you are a current smoker, are you interested in a cessation program? □ Yes □ No

Does patient drink alcohol? □ Yes □ No If so, how many drinks per week? □ 0 □ 1-6 □ 7-13 □14+

Has patient ever been treated for substance abuse or illegal drugs use? □ Yes □ No

If so, for what drugs/alcohol _____

If so, what type of treatment, where, and when? (e.g. “counseling: AA meetings, 2009-2010” or “inpatient recovery: Peachford Hospital, Aug. 2009”) _____

_____

Is patient interested in nutritional counseling and discussing daily diet? □ Yes □ No

Does patient have concerns about his/her weight? □ Yes □ No

If so, is patient interested in physician supervised weight loss? □ Yes □ No

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Section B. FOR CHILDREN ONLY (patients under 18)

Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian □ Other □ Declined

Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino □ Declined

Religious Affiliation: _____

School Grade: _____ School Attending: _____

Hobbies/Recreation (e.g. Sports, Music/Arts, Crafts):_____

_____

Exercise Hours Per Week: □ 0-10 □ 10-20 □ 20-30 □ 30-40 □ 40+

Is patient or parent/guardian interested in nutritional counseling/discussing daily diet? □ Yes □ No

Does patient or his/her parent/guardian have concerns about patient's weight? □ Yes □ No

Allergies:

Is patient allergic to tape or adhesives? □ Yes □ No Is patient allergic to latex? □ Yes □ No

Does patient have an allergy to medications? □ Yes □ No

If so, what drug(s) and what type of reactions (e.g. "throat closing" or "rash")?

_____

_____

Is patient allergic to any food items? □ Yes □ No Please list food and reaction: _____

_____

Does patient suffer from seasonal or environmental allergies? □ Yes □ No

Please list: _____

Why is patient seeking care today? Please list problem(s):

_____

_____

_____

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Review of Symptoms: Indicate any of the following symptoms patient has had in the past 6 months

Constitutional: □ None □ Fatigue □ Fever □ Night sweats □ Weight gain □ Weight loss

Cardiovascular: □ None □ Chest Pain/Pressure □ Heart Palpitations (Skipped Beats)

Skin: □ None □ Cellulitis □ Keloid □ Psoriasis □ Rash □ Redness □ Sores □ Warmth

Gastrointestinal: □ None □ Abdominal Pain □ Constipation □ Diarrhea □ Heartburn □ Nausea □ Vomiting

Genito-urinary: □ None □ Kidney Failure □ Pregnancy (if applicable)

Hematology: □ None □ Bleeding □ Blood Clots □ Bruising

Musculoskeletal: □ None □ Back Pain □ Bone Pain □ Decreased Range of Motion □ Joint Locking □ Joint Pain(s) □ Muscle Pain(s) □ Muscle Weakness □ Neck Pain □ Osteoporosis □ Shooting Pain □Swelling

Neurology: □ None □ Gait Abnormality □ Numbness and Tingling

Psychiatric: □ None □ Alcohol Abuse □ Anxiety □ Depression □ Drug Abuse □ Stress

Respiratory: □ None □ Emphysema □ Shortness of Breath □ Wheezing

Other Medical Problems for which the patient is being/has been treated:

□ Alcoholism	□ Cardiovascular Disease	□ Gastro Reflux	□ Kidney Disease	□ Pulmonary Embolism
□ Alzheimer	□ Cellulitis	□ Heart Disease	□ Liver Disease	□ Rheumatoid Arthritis
□ Anemia	□ Cirrhosis	□ Hepatitis	□ Lupus	□ Seizures
□ Arrhythmia	□ Deep Vein Thrombosis	□ High Cholesterol	□ Mental Illness	□ Stroke
□ Arthritis	□ Depression	□ High Blood Pressure	□ MS	□ Ulcers
□ Asthma	□ Diabetes	□ Hyperthyroidism	□ Osteoporosis	□ Other
□ Bleeding Disorders	□ Fibromyalgia	□ Hypothyroidism	□ Parkinson	□ Other
□ Cancer	□ Gastritis	□ Keloid	□ Psoriasis	□ Other

If other, please list: _____

List any previous surgeries and note the year they were performed to the right:

□ None	□ Breast	□ Foot	□ Knee	□ Tonsillectomy
□ Abdominal	□ Cardiac	□ Gall Bladder	□ Nasal	□ Vascular
□ Ankle	□ Ear	□ Hand	□ Ovary	□ Wrist
□ Appendectomy	□ Elbow	□ Hip	□ Prostate	□ Bladder
□ Back	□ Eye	□ Hysterectomy	□ Shoulder	□ Facial

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Indicate any other tests or treatments that the patient has had (include location and year):

□ Injection _____ □ X-rays _____

□ MRI _____ □ CT/CAT Scans _____

□ EMG _____ □ Physical Therapy _____

□ Other _____

Family History: Please check all that apply and indicate family relationship (parent, brother, sister or child) with any of the following conditions:

Condition	List Relative	Condition	List Relative
□ Alcoholism		□ Hearing Loss	
□ Allergies		□ Heart Disease	
□ Alzheimer Disease		□ High Cholesterol	
□ Anemia		□ Hypertension	
□ Arthritis		□ Hyperthyroidism	
□ Asthma		□ Hypothyroidism	
□ Bleeding Disorders		□ Kidney Disease	
□ Breast Cancer		□ Lupus	
□ Cancer		□ Mental Illness	
□ Cardiovascular Disease		□ Multiple Sclerosis	
□ Cerebrovascular Disease		□ Osteoporosis	
□ Crohn Disease		□ Parkinson Disease	
□ Degenerative Joint Disease		□ Prostate Cancer	
□ Depression		□ Rheumatoid Arthritis	
□ Diabetes		□ Seizures	
□ Eczema		□ Skin Cancer	
□ Epilepsy		□ Stroke	
□ Gastro Reflux (GERD)		□ Ulcerative Colitis	
□ Other (please describe using full line)			

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List any current medications the patient is taking:

Anti-Depressant:
□ Effexor (venlafaxine)
□ Cymbalta (duloxetine)
□ Prozac (fluoxetine)
□ Paxil (paroxetine)
□ Wellbutrin (bupropion)
□ Zoloft (sertraline)

Anti-Ulcer:
□ Prilosec (omeprazole)
□ Prevacid (lansoprazole)
□ Nexium (esomeprazole)
□ Protonix (pantoprazole)
□ Tagamet (cimetidine)
□ Zantac (ranitidine)

Allergy/Asthma:
□ Allegra (fexofenadine)
□ Claritin (loratadine)
□ Singulair (montelukast)
□ Zyrtec (cetirizine)
□ Albuterol Inhaler
□ Asthma-Steroid Inhaler
□ Nasal Steroids

Blood Thinners:
□ Aspirin
□ Coumadin (warfarin)
□ Refludan (lepirudin)
□ Ticlid (ticlopidine)
□ Plavix (clopidogrel)
□ Aggrastat (tirofiban)

Cholesterol Lowering:
□ Lipitor (atorvastatin)
□ Zocor (simvastatin)
□ Crestor (rosuvastatin)
□ Mevacor (lovastatin)
□ Niaspan (niacin)
□ Gemfibrozil
□ Zetia

Diabetes:
□ Insulin Injections
□ Glucophage (metformin)
□ Glucotrol (glipizide)
□ Glucagon
□ Avandia (rosiglitazone)
□ Precose (acarbose)

Cardiac/Hypertension:
□ Capoten (captopril)
□ Lisinopril
□ Cozaar (losartan)
□ Diovan (valsartan)
□ Dyazide
□ Nifedipine
□ Verapamil
□ Diltiazem
□ Norvasc (amlodipine)
□ Inderal (propranolol)
□ Tenormin (atenolol)
□ Lopressor (metoprolol)
□ Coreg (carvedilol)
□ Toprol

Pain Medications:
□ Darvocet
□ Fentanyl
□ Hydrocodone
□ Lyrica
□ MS Contin
□ Neurontin
□ Oxycodone
□ OxyContin
□ Percocet
□ Tylenol #3
□ Vicodin
□ Vistaril
□ Zanaflex

Antibiotics:
□ Amoxicillin
□ Augmentin
□ Bactrim (trimethoprim)
□ Biaxin (clarithromycin)
□ Cipro
□ Cleocin (clindamycin)
□ Doxycycline
□ Erythromycin
□ Keflex (cephalexin)
□ Levaquin (levofloxacin)
□ Lamisil
□ Sporanox (itraconazole)
□ Zithromax (azithromycin)

Anti-Inflammatory
□ Acetaminophen
□ Celebrex
□ Naproxen (Aleve)
□ Ibuprofen
□ Prednisone

Osteoporosis Treatment:
□ Actonel
□ Fosamax
□ Boniva

Reproductive:
□ Birth Control Pills
□ Depo-Provera Injections
□ Hormone Replacement

Other (including vitamins/supplements):

□ _____ □ _____ □ _____

□ _____ □ _____ □ _____

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Attestation Statement

I RELEASE THE ABOVE INFORMATION TO DR. DURBIN FOR USE IN MY TREATMENT AND ATTEST THAT THE INFORMATION CONTAINED IN THIS INTAKE FORM IS TRUE AND CURRENT TO THE EXTENT OF MY KNOWLEDGE.

Patient Signature: _____ Date: _____
(Or Parent/Legal Guardian)

Payment and Refund Policy

1. Payment is required in full at the time of service—we cannot process credit/debit cards at a date after service.
2. We require 12 hour notice to reschedule appointments. No-shows will result in a $25 appointment cancellation fee.
3. We are unable to accept checks.

NO REFUNDS WILL BE GRANTED FOR:

1. Any unlawful activity
2. Counterfeit or modified MRI report or any other documentation.
3. Failure to provide required medical records including, but not limited to the following:
    a. MRI
    b. Medical History
    c. Referral/Documents from previous physician
    d. Previous pharmacy records

Any refund requested for any reason other than those listed will be on considered on an individual basis.

If you have any questions you may speak to the office manager.

I UNDERSTAND THAT IT IS MY SOLE RESPONSIBILITY TO SEEK THIRD PARTY REIMBURESEMENT (e.g. submitting to Blue Cross Blue Shield or Humana), IF APPLICABLE.

Patient Signature: _____ Date: _____
(Or Parent/Legal Guardian)

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Notice of Privacy Practices for Protected Health Information

This notice describes how health information about you may be shared and how you can get access to this information, please review it carefully.

EFFECTIVE DATE: 07/17/2014

If you consent, the medical provider is permitted by Federal Law to make use of and disclose your health information for the purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our service to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment and applying for future treatment. It also includes billing documents for those services, if applicable.

An example of using your health information by a nurse is:

An employee of the provider's office obtains treatment information about you and records it in a health record. During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/ She will share the information with that specialist.

An example of using your health information for payment purposes:

We provide you with a receipt for payment, which you then submit for reimbursement to your insurance company. The insurance company requests information from us regarding the services that were rendered. We will provide that information to them about you and the care that you received.

An example of using this information for health care operations:

The state licensing authority wants to review records to assure that we have acted constant with state laws regarding your care. At the licensing authority request, we will provide a copy of your chart.

Your health information rights:

The health and billing records we collect during your visits are considered physical property of this office. The information in it, however, belongs to you.

You have the right to:

Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted. You may obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office that you are allowed to inspect and receive a copy of your health and billing records. You may exercise this right by delivering the request in writing to our office using the form we provide to you. You may appeal or deny access to your protected health information except in certain circumstances. You may request that your health care records be amended or corrected for incomplete or incorrect information. You may file a statement of disagreement if your amendment is denied and request that the request for amendment and any denial be attached in all future disclosures of your protected health information.

You may obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you. The accounting will not include internal uses of information for treatment, payment or operations. A request that the communication of your health information be made by alternative means should be made by delivering the request in writing to our office using the form we provide. You may revoke any authorizations that you made previously to use or disclose information, except to the extent information or actions have already been taken, by delivering a written revocation to our office.

YOU HAVE THE RIGHT TO REVIEW THIS NOTICE BEFORE SIGNING THE CONSENT AUTHORIZING USE OF DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION.

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Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. I understand the Notice of Privacy Practices.

I understand that this form will be placed in my patient chart and maintained for a period of at least six years.

Patient Name (Print) _____

Patient Signature: _____ Date: _____
(Or Parent/Legal Guardian)

THIS FORM WILL BE PLACED IN YOUR CHART AND MAINTAINED FOR AT LEAST SIX YEARS.

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Authorization for Release of Protected Health Information

Patients full name at the time of treatment: _____

Date of Birth: _____/_____/_____ Social Security number: _____-_____-_____

I authorize_____
(or other physician or health facility) to release my Medical Records to:

Randy E. Durbin, D.O., P.C.
5400 Laurel Springs Pkwy, Suite 1404
Suwannee, GA 30024

Information to be released (Please check all that apply):

□ Initial medical examination □ Progress notes from _____ to _____

□ X-Ray/CRCT/MRI Scan Reports □ Pharmacy Records

□ Lab Results □ Discharge Summary

□ Other_____

1) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, that this information will be released as part of my record.

2) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released.

4) I understand that a copy or FAX of this document is just as valid as the original document.

5) I understand that this notice will stay in my chart and be considered valid until I revoke this consent in writing, or until my patient-physician relationship with Dr. Durbin is dissolved.

Patient Signature: _____ Date: _____
(Or Parent/Legal Guardian)