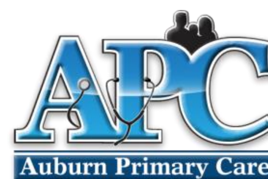
Auburn Primary Care, P.C.
Richard M. Schlossberg M.D.
Registration Form



Name: ____ ______________________________

DOB: _______________ Age: _________ SS#: __________________ DL#: __________________

Sex: ☐Male ☐ Female Marital Status: ☐Single ☐Married ☐ Widowed ☐ Divorced ☐ Separated

Address: ____

City:__________________________ St._______ Zip Code: ___________ County_______________

Home Phone: ____________________________ Cellular Phone: __________________________

Emergency Contact: ______________________________ Relationship: _____________________

Home Phone: ___________________________________ Work Phone: _____________________

Email Address: ____

Pharmacy: ____

Employee Status: ☐Full time ☐Part-Time ☐Unemployed ☐Retired

Employer: ____________________________________Phone:________________________________

Employer Address: ____

City: _____________________________ State: _______________ Zip: _______________________

Spouse Name: __________________________________ DOB: _____________________________

Employer: _______________________________________ Work Phone: _____________________

Student: ☐ Yes ☐ NO

School Name: ____

Insurance information must be totally completed to file insurance claims. Without a copy of your card and all information and all information you will be responsible for your total office visit at the time service.

Primary Insurance: ____

Policy Holder: ______________________________ DOB: ____________SS#: ________________

Secondary Insurance: ____

Policy Holder: _______________________________ DOB: __________ SS#: __________________

I authorize the release of any medical or other information necessary to process claims pertaining to my medical treatment. I authorize payment of medical benefits to Auburn Primary Care, or our authorized billing service. I understand it is my responsibility to inform this office of any changes in my insurance service and address information. I authorized the staff to perform the necessary medical services my child may need.

Signature: ____ _ Date: _____________________

AUBURN PRIMARY CARE

Richard M. Schlossberg, M.D.
12 Seventh Street, Suite A • Auburn, GA 30011

Please fill out our
PATIENT HISTORY FORM

Today's Date: __________ ☐ New Patient ☐ Annual Update Patient Chart # __________

Legal Name: __________ (Last / First / Middle) **Age:** ______ **Birthdate:** __________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Race:** ______

Home Address: __________

Home Phone __________ **Work Phone** __________ **Occupation:** __________

Family History

Has any blood relative had any of the following (please indicate which relative):

☐ Allergies ______	☐ Depression ______	☐ HIV/AIDS ______	☐ Migraine ______
☐ Anemia ______	☐ Diabetes ______	☐ Heart Disease ______	☐ Obesity ______
☐ Arthritis ______	☐ Drug/Alcoholism ______	☐ High Blood Pressure ______	☐ Osteoporosis ______
☐ Asthma ______	☐ Epilepsy ______	☐ High Cholesterol ______	☐ Stroke ______
☐ Bleeds Easily ______	☐ Glaucoma ______	☐ Kidney Disease ______	☐ Thyroid Disease ______
☐ Cancer ______	☐ Gout ______	☐ Mental Illness ______	☐ Tuberculosis ______
			☐ Other: ______

Father's Age: ____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased ______ Siblings ______
Mother's Age: ____ Health: ☐ Good ☐ Fair ☐ Poor ☐ Deceased ______ Spouse/Dependents ______

Personal History

Significant Hospitalizations/Surgeries/Injuries	Date	Current Medications
Drug Allergies and Reactions:		

Tobacco Use: ☐ Never Smoked ☐ <1/2 pack per day (ppd) ☐ 1/2 ppd ☐ 1 ppd ☐ 2 ppd ☐ >2 ppd, _____ ppd. Any smokers at home? ☐ Yes ☐ No
☐ Chewing Tobacco ☐ Dip Snuff; Stopped smoking ___/___/___ after ____ ppd for ____ yr. **Any other drug use? (list)** __________
Alcohol Use: ☐ Never drink ☐ Rarely drink ☐ I average _____ beers, ____ glasses/wine, ____ oz. mixed drink per: ☐ day ☐ week ☐ month ☐ year
Stopped drinking ___/___/___ after ___ yr; Any alcoholics in home? ☐ Yes ☐ No **Caffeine Use:** (coffee, tea, soft drinks) _____ cups/cans per day.

REVIEW OF SYSTEMS: Do you have now or have you had any of the following symptoms/diseases:

Main complaints today: 1. __________ 2. __________ 3. __________

Constitutional Symptoms
- ☐ Change in appetite
- ☐ Dizziness or fainting spells
- ☐ Night sweats or hot flashes
- ☐ Persistent fever
- ☐ Recent weight changes
- ☐ Sensitivity to cold or heat
- ☐ Sleeplessness
- ☐ Tire easily or weakness

Eyes
- ☐ Double or blurred vision
- ☐ Eye pain
- ☐ Eye infections-frequent
- ☐ Failing vision
- ☐ Wear glasses or contacts?
- ☐ Last eye exam __/__/__

Ear / Nose / Throat
- ☐ Decrease in hearing
- ☐ Discharge from ears
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Frequent nosebleeds
- ☐ Loss of smell
- ☐ Sinus trouble
- ☐ Dental problems
- ☐ Last dental visit __/__/__
- ☐ Persistent hoarseness
- ☐ Sore throat
- ☐ Sore tongue or gums

Cardiovascular
- ☐ Artificial heart valves
- ☐ Chest pain or discomfort
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular Pulse
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Palpitations or fluttering of heart
- ☐ Varicose veins

Respiratory
- ☐ Asthma / wheezing
- ☐ Bronchitis-chronic
- ☐ Chronic or frequent cough
- ☐ Emphysema
- ☐ Pneumonia / Pleurisy
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath lying flat
- ☐ Spitting blood or Phlegm
- ☐ Last chest X-ray __/__/__

Gastrointestinal
- ☐ Abdominal pain-chronic
- ☐ Bloody or black tarry stools
- ☐ Constipation ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Diverticulosis
- ☐ Heartburn / Indigestion
- ☐ Hemorrhoids
- ☐ Hepatitis / Yellow jaundice
- ☐ Nausea/Vomiting-persistent
- ☐ Ulcers
- ☐ Vomiting up blood

Genito-urinary
- ☐ Blood in urine
- ☐ Difficulty in starting urine
- ☐ Frequent urination (day)
- ☐ Frequent urination (night)
- ☐ Kidney stones
- ☐ Leakage in urine
- ☐ Painful urination
- ☐ Urine infections-frequent
- ☐ Venereal disease
- ☐ Lack of sex drive

Males
- ☐ Discharge from penis
- ☐ Impotence
- ☐ Pain or lump on testicles

Females
- Date last period started __/__/__
- Date of last PAP/pelvic __/__/__
- Date last mammogram __/__/__
- Age of menstrual onset ______
- Number of pregnancies ______
- Number of live births ______
- Number of miscarriages ______
- Number of abortions ______
- Type of birth control ______
- BC pill name: ______
- Flow: ☐ Heavy ☐ Mod ☐ Light
- ☐ Regular ☐ Irregular
- ☐ Pain/Cramps with flow
- ___ days of flow ___ length of cycle
- ☐ Pain with intercourse

Musculoskeletal
- ☐ Arthritis ☐ Gout
- ☐ Backaches-recurrent
- ☐ Joint Pain or stiffness
- ☐ Leg cramps while walking
- ☐ Leg cramps at night
- ☐ Muscle weakness
- ☐ Swelling of joints

Skin or Breast
- ☐ Change in nails or hair
- ☐ Easy bleeding or bruising
- ☐ Eczema ☐ Psoriasis
- ☐ Moles changing or always irritated
- ☐ Skin rash
- ☐ Lump or discharge from breast

Neurologic
- ☐ Headaches-frequent
- ☐ Paralysis ☐ Stroke
- ☐ Seizures
- ☐ Tremor/Hands shaking
- ☐ Poor coordination
- ☐ Numbness/Tingling sensations

Psychiatric
- ☐ Mental illness
- ☐ Moodiness - excessive
- ☐ Nervousness
- ☐ During the past month, have you been bothered by feeling down, depressed or hopeless?
- ☐ During the past month have you often been bothered by little interest or pleasure in doing things?
- ☐ Depression
- ☐ Memory loss
- ☐ Phobias
- ☐ Tearfulness
- ☐ Chronic fatigue

Endocrine
- ☐ Diabetes
- ☐ Increase in thirst
- ☐ Thyroid Disease

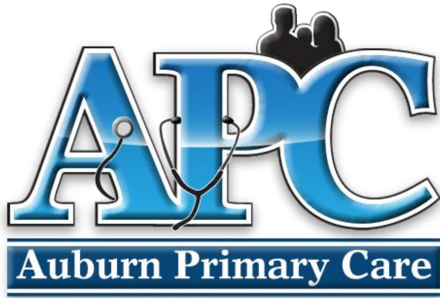
Hematologic / Lymphatic
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Swollen Lymph Nodes

Allergic / Immunologic
- ☐ Hayfever/Allergies ☐ Hives
- ☐ HIV / AIDS
- ☐ Chicken Pox
- ☐ Measles ☐ Mumps
- ☐ Rubella ☐ Polio
- ☐ Rheumatic Fever
- ☐ Syphilis
- ☐ Tuberculosis (TB)
- ☐ Tetanus

Please list any other concerns or comment on any of the above: __________

I affirm that the information I have given is correct and complete to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

Signature: __________ Date: __________



Richard M. Schlossberg, M.D.
12 Seventh St P.O. Box 717 Auburn, GA 30011

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Auburn Primary Care , P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Auburn Primary Care, P.C.'s Notice of Privacy provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Auburn Primary Care, P.C. reserves the right to revise its Notice of Practices at anytime. A revised Notice of Practices may be obtained by forwarding a written request to Auburn Primary Care, P.C. Privacy Officer at P.O. Box 717, 12 Seventh Street, Auburn, GA 30011

With this consent, Auburn Primary Care, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With the consent, Auburn Primary Care, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With consent, Auburn Primary Care, P.C. may e-mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Auburn Primary Care, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Auburn Primary Care, P.C. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Auburn Primary Care, P.C. may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

_________________________________   ___________________________

Patient's Name   Date

OFFICE POLICIES

Please read carefully and sign at the bottom. A copy will be provided to you upon request.

1. There is a $25.00 charge for all missed appointments and appointments not cancel within a 24-hours notice.

2. If you have lab work done, you will be called or contacted by mail within 5 business days of your appointment. Please do not call before then about lab work.

3. If you need a referral because of your insurance, you cannot make the appointment until you receive your referral from us. Please allow five business days for non-emergency referral.

4. If you are more than 15 minutes late for your appointment, you will have to re-schedule your appointment.

5. All refills will be called in if approved, within 24-hours Monday – Friday. Refills are done at the very end of the day when Dr. Schlossberg/Nurse Practitioner has finished with their last patient.

6. All nurse calls are done at the end of the day due to in house patient care.

7. No antibiotics will be called in unless you have been seen by the doctor/nurse practitioner for your condition within the week. The doctor/nurse practitioner cannot treat over the phone.

8. Due to the time the doctor/nurse practitioner spends with each of their patients, there is usually a wait time to be seen. If you feel you need to re-reschedule because of this wait, you will not be charged a $25.00 fee.

9. There will be a $40.00 charge for all insufficient fund check return.

10. Co-pays must be paid at the time of service per insurance agreement. We can not bill you for your insurance co-payment.

11. All past due balance must be paid before your visit, unless prior arrangements have been made with the practice.

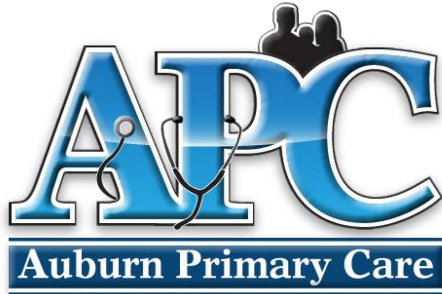
12. Before we will release your medical records all balances must be paid in full.
    I have read and understand the above policy and agree to abide by its terms.

_________________________________ _____________________________

Patient Signature Date

____

Print Name



Richard Schlossberg, M.D.

Trina McMillan, APRN.

NO SHOW POLICY

As a courtesy we attempt to make confirmation calls 48 hours in advance of your scheduled appointment, however you are responsible for keeping track of your appointment.

We would like to inform you that starting on January 01, 2008 there will be a $25.00 charge if you do not cancel your appointment 24 hours prior to your scheduled time.

A one-time consideration will be made for failure to show up for your appointment. Any no shows after that will be charged the $25.00 fee and payment must be made before another appointment may be scheduled.

Thank you for your understanding!

I have read the above no show policy and I understand that I will be charged if I fail to show up for my scheduled appointments.

______________________ ______________________

Patient/ Guardian Signature Print Patient/ Guardian Name

____

Date

Medicine Policy

1. I agree to take narcotic medication exactly as instructed. I am not allowed to change dosage, amounts, or alter the time schedule of taking the medication without first talking to my prescribing medical physician/nurse practitioner.

2. We will not refill prescriptions that have been lost, stolen, or misplaced. Please be responsible in keeping up with your narcotic/control substance prescription.

3. Only one pharmacy will be used for filling narcotic prescriptions.

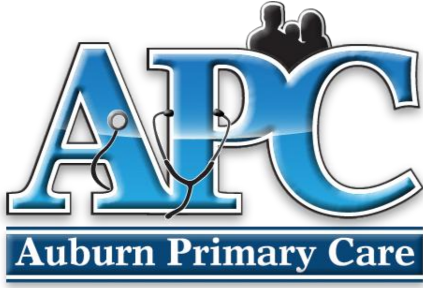
4. Obtaining narcotics from any other physicians while under our care without our knowledge, Dr. Schlossberg/Nurse Practitioner will not be able to refill any narcotics/control substance medication for you.

5. I will allow 24 hours for a prescription refill to be authorized. I also understand that request after 4:00 pm are handled on the next business day.

I have read and understand the above policy and agree by its terms.

________________________________ ________________________________
Patient's Signature Date

____
Print Name



Auburn Primary Care, P.C.

12 Seventh St

Auburn, GA 30011

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the notice of privacy practices detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law and outlining my rights regarding my protected health information (PHI)

____________________________________ ________________________

Signature of Patient and Legal Guardian Date

____

Relationship if not sign by patient: