Internal Medicine of Marietta
140 Vann St NE Ste 350
Marietta, GA 30060
PH: 770 771 5470
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Todays Date:_____

Patients Name: _____ Email _____

Male _____ Female_____ Date of Birth _____ SS#_____/_____/_____

Home ph no_____,Cell ph no_____Alt ph no_____

Home Address_____

City_____State_____ Zip_____

Occupation_____Employer_____

Employers ph no:_____

Current Insurance Co_____ ID#_____

Effective date:_____

Emergency contact:_____Relationship:_____

Ph No:_____

Family History : Siblings_____

Mother:_BP_____Diabetes_____Heart disease_____Cancer_____type_____
Father:__BP_____Diabetes_____Heart Disease_____Cancer_____type_____

GrandMother_____

GrandFather_____

Anyone in the family with the following:

____Asthma ____Allergies ____Bleeding Problems _____Cancer _____Seizures

_____Diabetes _____High Cholesterol _____High Bp _____Heart Disease _____Stroke ____TB

Personal History:

Allergies:None_____sulfa_____ Penicillin_____ Other_____

Social History: smoker____ alcohol _____

Past Illnesses: High bp____ heart disease_____ Diabetes_____thyroid_____ HIV or AIDS_____

Cancer___Type____ Asthma_____Abnormal Pap_____TB____Kidney Disease_____STD_____

Other_____

Past Surgical History: Appendix____Gall Bladder_____Thyroid_____Hernia____Hysterectomy_____

Other_____

Preventive Screening:last Pap____Mammogram____ Colonoscopy____Prostate screening_____

Bone Density_____Shingles vaccine_____Pneumonia vaccine_____tetanus shot_____

I Have a living will_____ I would like to learn about it_____ I have a durable power of attorney _____

Signed_____Date_____

I authorize Internal Medicine of Marietta,to disclose my health information with the following persons:

1)_____relationship_____

2)_____relationship_____

3)No disclosure at this time_____

Signed_____Date_____

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.The provider will not deny treatment whether or not I sign this authorization for disclosure.I also understand I can revoke this authorization at any time,in writing, but this does not effect any protected health information previously released.

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICE" FOR PROTECTED HEALTH INFORMATION

I, acknowledge that I have received a copy of the Internal Medicine of Marietta's "NOTICE OF PRIVACY PRACTICE " for Protected Health Information of the date set forth below

Date of Receipt_____ Patient Name_____

Signature of Patient or Patient Representative_____

Name of Patient Representative if not signed by patient_____

Relationship to Patient_____