

# DAVID CORNELL, M.D.

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## PATIENT INFORMATION REGISTRATION FORM

(PLEASE PRINT CLEARLY)

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone (Cell, etc.) \_\_\_\_\_

S.S. #: \_\_\_\_\_ Email: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

### **REFERRAL INFORMATION** (Please tell us how you were referred to our practice)

Source: \_\_\_\_\_

### **PATIENT AUTHORIZATION**

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:** I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:** I authorized payment of medical benefits to the undersigned physician or supplier for service described below.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

### **NOTE:**

Please provide us with your driver's license and insurance card(s) so that we may make photocopies of them.

Please review our Notice of Privacy Policies as required by the Health Insurance Portability and Accountability Act of 1996, HIPAA. If you have any questions, we would be more than happy to answer them for you.

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## Patient History

Note: This is a confidential record and will remain in your doctor's office. Information contained here will not be given to anyone without your authorization to do so.

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Physical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

### Chief Complaint

What is the main reason of your visit today?

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## Past Medical History

List any significant past illnesses:

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List all current medications:

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List any prior operations:

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Do you have any medication allergies? Yes No  
If yes, please list.

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Do you have any unusual bleeding? Yes No  
If yes, please explain.

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Are you taking any Aspirin, ibuprofen, or any other drugs that may cause blood thinning? Yes No  
If yes please list.

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**(OVER)**

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## Review of Systems

Do you now or have you had any problems related to the following systems?  
Please Circle **Yes** or **No**. Provide explanation if necessary.

### **Constitutional Systems**

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

### **Eyes**

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

### **Allergic/Immunologic**

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

### **Neurological**

Tremors	Y	N
Dizzy spells	Y	N
Numbness	Y	N
Other _____		

### **Endocrine**

Excessive thirst	Y	N
Too Hot/Cold	Y	N
Tired/sluggish	Y	N
Other _____		

### **Gastrointestinal**

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion	Y	N
Heartburn	Y	N
Other _____		

### **Cardiovascular**

Chest pain	Y	N
Varicose veins	Y	N
High Blood Press	Y	N
Other _____		

### **Skin**

Rash	Y	N
Boils	Y	N
Persistent	Y	N
Other _____		

### **Musculoskeletal**

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

### **Genitourinary**

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

### **Respiratory**

Wheezing	Y	N
Frequent cough	Y	N
Short Breath	Y	N
Other _____		

### **Hematologic**

Swollen glands	Y	N
Blood clotting	Y	N
Other _____		

### **Psychological**

Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Are you satisfied with your life?	Y	N
Other _____		

Physician: \_\_\_\_\_

Date: \_\_\_\_\_

# PATIENTS RIGHTS AND RESPONSIBILITIES

(As required by the Health Insurance portability and Accountability Act of 1996, HIPAA)

You, as the patient, have the right to.....

## Access to Care:

Impartial access to treatment that is medically indicated regardless of color, age, creed, sex or national origin.

## Respect and Dignity:

Considerate, respectful care at all times and under all circumstances, including reasonable attempts to respect religious and cultural beliefs and practices and to make efforts to accommodate whenever possible.

## Privacy and Confidentiality:

- Be interviewed, examined and treated in surroundings designed to provide reasonable privacy.
- Have your medical record read only by those directly involved in your care, in the monitoring of the quality of that care, or by those designated to you.
- Review your medical record and to have information explained, except when restricted by law.
- Expect information related to your office care will not be released without your permission.
- Expect that discussions related to your care will occur in private and include only those with a specific need to know.

## Participate in Treatment Discussions:

- Be informed and to participate in decisions concerning your care.
- Be given a clear and understandable explanation of procedures including the reason why a procedure is needed, the risk and benefits, probability of success and possible alternatives.
- Complete an advanced directive to indicate your treatment preferences should you become unable to make your own decisions in the future.
- Refuse treatment to the extent permitted by law.
- Be informed of any research activities that affect your care and to choose voluntarily to participate. Refusal to participate will not compromise care.

## Personal Safety:

- Expect reasonable safety related office practices and environment.

## Information:

- Be informed about your illness, possible treatments and likely outcome.
- Know the names and roles of caregivers.
- Know the relationship the physician has with outside parties (such as healthcare providers or insurers) that may influence your treatment and care.

## Transfer and Continuity of Care:

- Expect that the physician will provide necessary health services to the best of his/her ability. If a transfer of care is recommended, you will be informed of the

benefits and alternatives. You will not be transferred without your consent and until another physician agrees to accept you.

Understanding Charges:

- Be billed fairly for only those services provided.
- Request an itemized bill for services rendered.
- Ask questions and receive assistance in understanding charges and payment methods.
- Receive timely notice prior to termination of eligibility for reimbursement by any third party payer for the cost of care.

You as the patient, have the responsibility to...

- Provide caregivers with accurate and complete information about your health and convey understanding of what is expected in regard to your treatment.
- Comply with instructions for your treatment plan. If you believe that you cannot follow through with treatment, you are responsible for telling your physician.
- Meet your financial obligations as promptly as possible.
- Be considerate of the rights of other patients and personnel in the control of noise and the respect of property.

## GEORGIA'S PATIENT'S RIGHT TO KNOW ACT OF 2001

Georgia's *Patient Right to Know Act*, passed during the 2001 legislative session of the Georgia General Assembly, requires physicians to post a notice in their waiting rooms advising their patients of certain rights effective April 11, 2001.

- The patient has the right to file a grievance with the Composite State Board of Medical Examiners concerning the physician, his/her office and treatment received. The patient should either call the Board with such a complaint or send a written complaint to the Board.

**Composite State Board of Medical Examiners  
2 Peachtree Street, N.W. 10<sup>th</sup> Floor  
Atlanta, GA 30303-3456  
(404) 656-3913**

- The Board is required to investigate every grievance filed and respond in writing.
- The Board will create physician profiles available to the public. (information such as doctor's education, experience, disciplinary actions, malpractice judgments, or felony convictions.)
- The patient has the right to inquire about the cost of treatment prior to receiving treatment.

I \_\_\_\_\_ have read given a copy, and understand  
Patient Right to Know Act. Date: \_\_\_\_\_