GEORGIA
INTERVENTIONAL MEDICINE

(404) 267-5566 FAX: (404) 267-5565
SCHEDULING@GAINTERVENTIONALMEDICINE.COM
WWW.GAINTERVENTIONALMEDICINE.COM
CHAMBLEE - 3286 BUCKEYE RD., ATLANTA, GA 30341

NEW PATIENT INTAKE FORM

PATIENT REGISTRATION INFORMATION		
Name:	Date of Birth:	Sex:
Preferred language (if not specified, English will be chosen as your preferred language:		
Email:		
Home Address:	Mailing Address (if different):	
Home Phone: Mobile Phone: Work Phone:		
Reason for visit/Diagnosis:		
Primary Care Physician:	**Referring Physician:**	
Pharmacy: Name Address:		
Guarantor/Responsible Party		
Name:	Date of Birth:	
Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____		
Home Address:	Mailing Address (if different):	
Home Phone: Mobile Phone: Work Phone:		
Emergency Contact(s)		
Name:	Date of Birth:	
Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Home Address: City: State: Zip:		
Name:	Date of Birth:	
Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Home Address: City: State: Zip:		
Insurance		
PRIMARY INSURANCE Name:	Attorney:	
Subscriver/Member ID#:	Case Manager:	
Group#:	Phone:	
Subscribe Name:		
Address:		
Employer:		
Date of Birth:		
Relationship to Patient:		

- I hereby authorize Georgia Interventional Medicine to obtain records from other sources as may be needed in the treatment of this patient.
- I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatement of this patient.

A copy of this information shall be as valid as the original.

_____ _____

Signature of parent or responsible party Date

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NEW PATIENT INTAKE FORM

Patient Name:	Date of Birth:

CHIEF COMPALINTS:

REVIEW OF SYSTEMS					
Neck	☐ Left	☐ Right	Headaches	☐ Yes	☐ No
Shoulders	☐ Left	☐ Right	Visual Disturburances	☐ Yes	☐ No
Arms	☐ Left	☐ Right	Light Sensitivity	☐ Yes	☐ No
Hands	☐ Left	☐ Right	Nausea	☐ Yes	☐ No
Mid-Back	☐ Left	☐ Right	Chest Pain	☐ Yes	☐ No
Rib Pain	☐ Left	☐ Right	Shortness of Breath	☐ Yes	☐ No
Low Back Pain	☐ Left	☐ Right	Shoulder Muscle Tension	☐ Yes	☐ No
Hips	☐ Left	☐ Right	Back Muscle Tension	☐ Yes	☐ No
Buttocks	☐ Left	☐ Right	Muscle Weakness	☐ Yes	☐ No
Legs	☐ Left	☐ Right	Radiating Pain	☐ Yes	☐ No
Swelling in Legs	☐ Left	☐ Right	Numbness	☐ Yes	☐ No
Ankles	☐ Left	☐ Right	Tingling	☐ Yes	☐ No
Muscle Cramps	☐ Left	☐ Right	Incontinence of Bladder	☐ Yes	☐ No
Feet	☐ Left	☐ Right	Incontinence of Bowel	☐ Yes	☐ No

ALLERGIES:

☐ Yes ☐ None If Yes, please list:

Immunizations up to date: ☐ Yes ☐ No ☐ Decline

PAST HISTORY:

Hospitalizations, Sugeries, Major Illnesses:

Problem:

Problem:

Problem:

Problem:

Problem:

PATIENT MEDICAL HISTORY:						**TREATING OFFICE:**
ADHD	☐ Yes	☐ No	Spine Surgery	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	Physical Therapy	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	Chiropractic	☐ Yes	☐ No	
Chronic Lung Disease	☐ Yes	☐ No	Brace Support	☐ Yes	☐ No	
Congenital Heart Disease	☐ Yes	☐ No	Hot/Cold Packs	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	Massage Therapy	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	TENS Unit	☐ Yes	☐ No	
Mental Illness	☐ Yes	☐ No	Muscular Dystrophy	☐ Yes	☐ No	
Obesity	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No	
Prematurity	☐ Yes	☐ No		☐ Yes	☐ No	

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NEW PATIENT INTAKE FORM

Patient Name:	Date of Birth:

Relationship	Name	Age/ Staus	Hypertension	Heart Surgery	Heart Attack	High Blood Pressure	Stroke	Dyslipidemia	Diabetes	Obesity	Cardiomyopathy	Pacemaker	Sudden Death	Long QT Syndrome	Drowning	Passing Out	Seizures	Marfan's Syndrome	Deafness at Birth	Other
Mother																				
Father																				
Sister																				
Brother																				
Maternal Grandmother																				
Maternal GrandFather																				
Paternal Grandmother																				
Paternal GrandFather																				
Other																				

SOCIAL HISTORY: Check all that apply to the patient

Exercise: ☐ Occasionally ☐ Daily ☐ Competitive Athlete ☐ Recreational

Diet: ☐ Usual American ☐ Low Fat ☐ Low Salt ☐ Vegatarian ☐ Other _____

Smoking: ☐ N/A ☐ No. of packs a day ☐ Age started _____

Alcohol: ☐ N/A ☐ Type:_____ ☐ Amount: _____day/week/month

Sexual Activity: ☐ N/A ☐ Yes ☐ No ☐ Currently pregnant

CURRENT MEDICATIONS: (list all medications including over the counter medications/vitamins)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Do you take antibiotics prior to any procedures, operations or appointments? ☐ Yes ☐ No

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LETTER OF PROTECTION AND NOTICE MEDICAL LIEN

Patient's Name: _____

First Date of Service: _____

Attorney's Name: _____

County in which legal case is pending: _____

I do hereby authorize you _____ (name of attorney) as my attorney to pay Georgia Interventional Medicine, LLC (hereinafter "GIM") for medical services out of any proceeds that I receive as a settlement, judgment or verdict from my pending legal case.

I understand that the settlement or award amount may not cover part or all of the medical services rendered by GIM. I fully understand that I am financially responsible for and agree to pay all charges which are not paid by the settlement, judgment or verdict in the case, if not settled with attorney.

I hereby authorize and direct you as my attorney to pay directly to GIM such sums as may be due and owed to GIM for medical services rendered. I hereby further give a lien on my case to GIM against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to GIM for all medical bills submitted by GIM for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify GIM of any charge or additional of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s). I have been advised that if my attorney does not wish to cooperate in protecting GIM's interest, GIM will not await payment, but will declare the entire balance due and payable. I have had an opportunity to review the terms and conditions of this lien and have had the opportunity to obtain advise of counsel. I enter into this agreement knowingly and willingly.

Patient's Signature: _____ Date: _____

Attorney Signature: _____ Date: _____

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MEDICATION AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician to comply with the law regarding pain-control medications. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this Agreement.

I understand that if I breach this Agreement my physician will be forced to stop prescribing pain-control medications.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication is helping to relieve the pain.

I will not share, sell or trade my medication with anyone.

I will safeguard my medication from loss or theft. Lost or stolen medications cannot be replaced.

I agree that only one physician may prescribe pain medications. If pain medications are received from other physician practices, our clinic will be unable to prescribe pain medications thereafter.

I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours.

I authorize my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my medications.

I authorize my physician to provide a copy of this Agreement to my pharmacy if necessary.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this Agreement and the medications presented for pain management.

I agree that I will use my medication as prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to follow these procedures that have been fully explained to me. All of my questions and concerns regarding my medications have been adequately answered.

A copy of this Agreement has been given to me. Nothing herein shall be deemed to alter the discretion of my physician to use his best judgment in recommending treatment and medication options.

This Agreement is entered into on this _____ day of _____, _____.

Patient signature: _____

Witnessed by: _____

Physician signature: _____

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ACCIDENT INFORMATION FORM

1.) Date of accident: _____ Did you go to ER or see a doctor? If so, when, where, and what happened?

_____

_____

_____

2.) Did either driver receive a citation or ticket from the police? If so, who received the citation/ticket?

_____

3.) Do you have MEDPAY with your car insurance? If so, please provide MEDPAY information:

_____

_____

_____

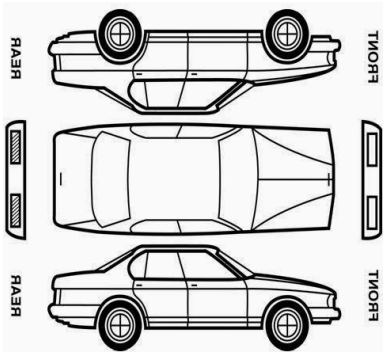
4.) Who was the at fault driver? You? Driver of the other vehicle? Unsure?

_____

_____

5.) Vehicle Damage: ____ None ____ Scratch ____Dent ____Total Loss

What area and percentage of your car was damaged?



Signature _____ Date: _____

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____

I _____ authorize representatives from the following facility(s) to disclose health information as directed below to release records by mail or fax copies to:

_____ release to: Georgia Interventional Medicine – 3286 Buckeye Road, Atlanta, GA 30341
_____ obtain from:
_____ exchange with:
_____
_____

the following information pertaining to myself: _____
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ medication history
_____ other (specify) _____

for the purpose of:
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____
Signature of Client Date

_____
Signature of Witness Date

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TRANSPORTATION FEES

UBER CHARGES for each way

$10.00 CANCELLED UBER

$20.00 0-10 MILES

$30.00 10-20 MILES

$40.00+ 20 MILESS AND UP

For multiple passengers or large UBER premium vehicles there will be an additional charge.(That charge is what UBER charges us).

PRINT NAME SIGN NAME DATE

Please sign that you understand the above charges will be charges to you or your attorney should you fall into one or more of the above categories.

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NO SHOW / CANCELLATION POLICY

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. In return, it is your responsibility to make every effort to keep your scheduled appointments and arrive promptly at the time instructed. However, we realize that unanticipated events may prevent you from keeping your appointment. In fairness and consideration to our other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment. If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your scheduled office appointment and 48 hours before your scheduled procedure time to avoid paying a fee. In an effort to see patients promptly at the scheduled time, this office does not double-book appointments; therefore, the 24 / 48-hour notification is necessary so that we may schedule other patients needing immediate appointments.

The fees are as follows:

Missed office appointment is **$50.00**

Missed MRI appointment is **$100.00**

Missed procedure appointment is **$100.00**

Patient's Signature: _____ Date: _____