PRESTIGE
Family Medicine

NEW Patient Demographics

Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Email: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Emergency Contact: _____ Relationship: _____

Place of Employment: _____ Pharmacy Name/Location: _____

Ethnicity (Circle one): African American Asian Caucasian Hispanic Indian Other: _____

Language (Circle one): English Spanish Other: _____

Insurance Information

Primary Insurance: _____

Policy Number: _____ Group: _____

Insurance Address: _____

Relationship to Policy Holder: _____ Date of Birth of Policy Holder: _____

Secondary Insurance: _____

Policy Number: _____ Group: _____

Insurance Address: _____

Relationship to Policy Holder: _____ Date of Birth of Policy Holder: _____

Assignment of Benefits

The above information is true to the best of my knowledge. I hereby consent to and authorize the provision of all treatment and performance of all examinations which, in the judgment of my provider, may be considered necessary or advisable for my diagnosis and/or treatment while I am a patient of Prestige Family Medicine. I understand that on occasion, the services that I receive may be performed by a Certified Physician Assistant under the supervision of a licensed physician. To provide continuity of care, I authorize the release of medical information to other physicians. I authorize my insurance to release any benefits to be paid directly be paid directly to the physician. I authorize Prestige Family Medicine to release to their insurance company information required to process required to process my claims. I understand that I alone am responsible for charges resulting from my treatment and care.

Signature of Patient /Legal Representative: _____

Date: _____

What complaints are you having today? _____

When did you first notice the problem/symptoms: _____

Did you have other problems at the same time these symptoms started: _____

If yes, what were the symptoms_____

How often do you have the problem/symptoms? _____

How long does the problem/symptom last? _____

Does anything make your problem/symptoms better? _____

Does this problem/symptom affect your sleep? _____

How does this affect your life? _____

Have you been evaluated for this problem/symptom before? Yes or No

If so when and where:_____

What was the diagnosis given and was treatment provided? _____

What treatment and how often did you receive it? _____

Is there anyone in your family with similar problem/symptoms _____

Last Flu Vaccine	**Date:**
Last Pneumonia Vaccine	**Date:**
Last Colonoscopy	**Date:**
Last PSA	**Date:**
Last Mammogram	**Date:**
Last Pap Smear	**Date:**

Past/Current Medical History (circle all that apply):

Anemia	**Asthma**	**Arthritis**
Bleeding/Clotting Disorder	**Cancer** **Type: _____ Age: _____**	**Cataracts**
Dementia	**Diabetes** **Age of Onset: _____**	**Emphysema**

Gallbladder Disease	**GERD**	**Hepatitis: Circle One** **Type A, Type B, Type C**
Herat Disease	**High Blood Pressure**	**High Cholesterol**
Influenza	**Kidney Failure/Disease**	**Kidney Stones**
Jaundice	**Measles/Mumps/Chicken Pox**	**Mental Illness: Circle One** **Depression, Anxiety, PTSD, Bipolar**
Poliomyelitis	**Rheumatic Fever**	**Sexually Transmitted Disease:** _____
Seizures	**Skin Lesions**	**Sickle Cell Disease**
Stroke	**Thyroid Disease**	**Tuberculosis**
Any other Medical Illness: _____		

Surgeries:

Date	Type	Location of Surgery

Hospitalizations: Yes/No

Date & Where: _____

Date & Where: _____

Injuries/Accidents: Yes/No

What type of Injury or accident and date? _____

What type of Injury or accident and date? _____

What type of Injury or accident and date? _____

List Medications/Supplements and Dosage and prescribed by

Allergies/Type of Reaction:

1. _____
2. _____
3. _____
4. _____
5. _____

Name of Specialist Physicians:

1. _____
2. _____

Family Medical History:

Mother's age: _____ Alive? Yes/No

Mother's Health Problems: _____

Father's age: _____ Alive? Yes/No

Father's Health Problems: _____

Any Siblings: Yes/No How Many Brothers: _____ How Many Sisters: _____

Brother's Health Problems: _____

Sister's Health Problems: _____

Social History:

Education of Level (check one): ☐ High School Graduate ☐ College ☐ Graduate Program

Current Occupation: _____Employer: _____Years employed _____

Marital Status (check One): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Habits:

Tobacco Use (check one): ☐ Cigarettes ☐ Snuff ☐ Chewing ☐ Pipes/Cigars: Present/Past Packs per Day _____

Alcohol: Present/Past How much/often _____

Illicit Drug Use: Present/Past If so what type of drug: _____

Exercise: Present/Past How much/often: _____

Please circle any of the following symptoms that you have had in the last 6 months:

Fatigue	Seasonal Allergies	Anemia	Bleeding Disorder	Skin Disorders
Excessive Hair Growth	Head Trauma	Gland enlargement/pain	Hearing loss	Ear Infection/pain
Nose Bleeds	Runny Nose	Frequent Sinus/Nasal Infection	Difficulty Swallowing	Mouth Pain
Sore Throat	Ringing in ears	Hoarseness/Change in voice/Neck pain/stiffness	Excessive Sweating	Weight
Breast lumps/Nipple discharge/change in size	Hair Loss	Increased thirst/urination/hunger	Chest Pain	Shortness of breath
Headaches	Memory loss/change	Palpitations	Swelling of hands/feet	Cough
Night sweats	Nausea/vomiting	Diarrhea	Abdominal pain	Fecal incontinence
Change in bowel movement	Flatulence	Blood in stool	Painful urination	Dizziness
Erectile dysfunction	Loss of smell/taste	Change in menstrual cycle	Falls	Muscle weakness
Involuntary muscle movement	Speech problems	Tingling in extremities	Muscle cramps/pain/spasms	Depression/Anxiety
Difficulty concentrating	Mood Swings	Sleep Disturbances		

Patient Signature _____Date_____

Physician Signature _____Date_____

Patient Acknowledgement Form

Patient acknowledgement of Understanding of Prestige Family Medicine

Patient Name: _____Date of Birth_____

I understand that the patient's health information is private and confidential. I understand that Prestige Family Medicine works very hard to protect the patient's privacy and preserves the confidentially of the patient's personal health information. I understand that Prestige Family Medicine may use and disclose the patient's health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations. Prestige Family Medicine, has a detailed document called the "Notice of Privacy Practices." It contains more information about policies and practices protecting the privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice" before signing this acknowledgement. Prestige Family Medicine, may update this Acknowledgment and "Notice of Privacy Practices." If I ask, Prestige Family Medicine; will provide me with the most current "Notice of Privacy Practices." Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but not limited to, access to my medical records; restrictions on certain uses, receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternate location. Prestige Family Medicine has established procedures which help the office meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations, reasonable time frames for requesting information, charges for copies and nonroutine information needs, etc. I will assist Prestige Family Medicine by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of Prestige Family Medicine "Notice of Privacy Practices."

Patient or Legally Authorized Individual Signature _____Date_____

Relationship to Patient: _____

PRESTIGE
Family Medicine

Medical Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Prestige Family Medicine. When you schedule an appointment with Dr. Shikha Shah we set aside enough time to provide you with the highest quality of care. Should you need to reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. Please see our Appointment Cancellation/No Show Policy below:

1. Any established patient that fails to show or cancel/reschedule an appointment and has not contacted the office without at least 24-hour notice will be considered a No Show and a $25 fee will incur.
2. The fee will not be billed to the insurance company, but directly to the patient and will be due at the next scheduled appointment.
3. As a courtesy, when time allows, we make reminder calls for appointments. However, if you do not receive a reminder call or we had to leave a message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency arises and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office manager, who may be able to waive the No Show fee. You may contact Prestige Family Medical during normal business hours Monday thru Friday 8:00 a.m.-4:30 p.m.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to the terms.

Patient or Legal Representative Signature: _____Date_____

Relationship to Patient: _____Printed Name: _____

PRESTIGE
Family Medicine

Alternative Communication Release Form

I authorize Prestige Family Medicine in regards to my protected health information:

_____To speak with anyone listed on the Right to Share Information list, and to give my prescriptions to them as indicated below.

_____To speak only with me.

Right to Share Information with Family and Friends

Prestige Family Medicine reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy Practices.

In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals that we are authorized to release information to.

	Is Allowed to Pick up Prescriptions	
_____ **Name**	Yes	No
_____ **Name**	Yes	No
_____ **Name**	Yes	No
_____ **Name**	Yes	No

_____ **Patient Name (printed)**

_____ **Date of Birth**

_____ **Signature of Patient**

_____ **Date**

PRESTIGE
Family Medicine

Immunization Consent Form

Patient Name: _____DOB: _____Age_____

Address: _____City_____State_____Zip_____

Phone Number _____

Precautions and Contraindication: Please Mark Yes to All that apply:

For inactive and Live Vaccines

Are you at least 18 years of age or older: _____

Do you have a cold, fever or acute illness? _____

Are you allergic to chicken eggs or egg products? _____

Do you have any allergies to medications, food, or vaccines? _____

Are you allergic to thimerosal? _____

Have you ever had a serious reaction after receiving a vaccination? _____

Do you have a seizure, brain, or nerve problem? _____

Have you ever been diagnosed with Guillain Barre Syndrome? _____

Have you had a physical exam within the last year? _____

Live Vaccines Only

Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as: High dose steroids or cancer treatment with radiation or chemotherapy?_____

Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation? _____

During the past year have you received a transfusion of blood or blood products or been given a medication called Immune (Gamma) Globulin? _____

For WOMEN: Are you pregnant/chance you could become pregnant during the next month? _____

Have you received any vaccinations in the past 4 weeks? _____

For Intranasal Influenza: Do you have a long-term health problem such as heart, lung, kidney, liver, or metabolic disease, neurological or neuromuscular disease, anemia, or blood disorder? _____

I voluntarily request and consent that I be administered the following vaccine_____. I acknowledge that Prestige Family Medicine has given me a copy of the Vaccine Information Statement that contains information about the vaccine including information on certain adverse reactions that I may have as a result of receiving the vaccine. I have carefully read and understand the vaccine information statement and have had an opportunity to ask questions about the vaccine that I am receiving. This authorization includes disclosures to regulatory agencies. Prestige Family Medicine shall not at any time to any extent allowable by applicable law be liable, responsible, or any way accountable for any loss, injury, death, or damages suffered by me in connection with or as a result of the administration of the vaccine. By signing below, I certify that I am the patient or the patient's guardian/personal legal representative of the patient that I have read, understand, and agree to all the statement in this form as listed above.

Patient Signature: _____ Relationship to Patient: _____ Date:_____

PRESTIGE
Family Medicine

Date: _____
Patient Name: _____
Date of Birth: _____

Please place a check mark beside any of the following symptoms or problems if you have experienced them recently or have concerns about them.

A. **General:**
- ____Fevers, chills or sweat
- ____Recent loss of appetite
- ____Fatigue
- ____Recent unexplained weight loss

B. **Eyes:**
- ____Blurred or double vision
- ____Eye pain or irritation
- ____Eye pain

C. **Ears, Nose and Throat:**
- ____Earache
- ____Ringing in ears
- ____Difficulty swallowing
- ____Frequent nose bleeds
- ____Sore Throat
- ____Congestion

D. **Cardiovascular:**
- ____Chest pain
- ____Fainting spells
- ____Palpitations
- ____Shortness of breath with exertion
- ____Swollen limbs

E. **Respiratory:**
- ____Cough
- ____Chronic Shortness of breath
- ____Wheezing
- ____Coughing up blood

F. **Gastrointestinal:**
- ____Nausea/Vomiting
- ____Diarrhea
- ____Constipation
- ____Abdominal pain
- ____Bloody or black stool

G. **Skin:**
- ____Rash
- ____Itching
- ____Chronic dry skin

H. **Neurologic:**
- ____Headache
- ____Weakness
- ____Numbness/tingling sensations
- ____Seizures
- ____Fainting
- ____Dizziness/vertigo

I. **Urinary:**
- ____Painful urination
- ____Blood in urine
- ____Increased urination
- ____Urgency to urinate

J. **Musculoskeletal:**
- ____Back pain
- ____Joint pain
- ____Muscle cramping
- ____Muscle weakness
- ____Swelling of joints

K. **Psychological:**
- ____Feeling depressed
- ____Memory loss
- ____Difficulty concentrating

Women Only:
Last Menstrual Period _____
Age of Menopause _____

Allergies to medications, IV dye, etc.:

_____
_____

Do you need any medication refills today? ____Yes ___No
Which medications? _____
_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Ad. of 1996 (HIPAA) Privacy Standards.

Print Name of Patient _____

Date of Birth: _____SSN: _____

I hereby authorize and request my health record from: _____to disclose the **following health information.**

□ - All my health information

□ - My health information relating to the following treatment or condition:

_____

□ - Other: _____

The **above party** may disclose this health information to the following recipient.

Prestige Family Medicine
Shikha Shah, MD

6200 Bradley Park Dr
Columbus, GA 31904
Phone: 706-691-8080 Fax: 888-905-2571

The purpose of this authorization is (check all that apply): □ - At my request.

□- Other: Continuity of medical care

This authorization ends:

□ - On (date),_____or one hundred twenty days.

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain Insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will **receive a** copy of this authorization after I **have** signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PRESTIGE
Family Medicine

Patient Name:_____ Date:_____

STOP-BANG Sleep Apnea Questionnaire

S (snore)	Do you SNORE?	Yes	No
T (tired)	Do you often feel TIRED or sleepy during the daytime?	Yes	No
O (observed)	Has anyone OBSERVED you stop breathing during your sleep (even	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 35?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Is your NECK circumference 16 inches or greater?	Yes	No
G (gender)	Is your GENDER male?	Yes	No

The more Yes's you have the more likely you are to have obstructive sleep apnea. Speak with your healthcare provider about your results.