
PATIENT INFORMATION PROFILE

Dr. Robert Hill, M.D.
Dr. Dennis Jones, M.D.
Dr. Michael Blaney, M.D.
Dr. Wendy Davis, M.D.
Dr. Arthur Chasen, M.D.
Dr. Steven Roth, M.D.

Have you ever been a patient in this office for any doctor? Yes _____ No _____

Patient's Full Name: _____
(please print) (First) (Middle) (Last) (name called)

Mailing Address: _____
(Street / apt #) (City) (State) (Zip)

(Area code) (Phone #) (Cell #) (Work #)

(Date of Birth) (Age) (Sex) (Marital status) (Religion)

(Social Security #) (employer) (employer phone # & ext.)

(Spouse's name) (Spouse's employer & phone #)

(Spouse's Date of Birth) (Spouse's SS #)

Please state reason for seeing doctor today: _____

Dr. that referred you here: _____

Drug allergies: _____

Primary Care Physician: (PCP) _____

DO YOU HAVE ANY OBJECTION TO BLOOD TRANSFUSIONS? YES ___ NO ___

Emergency contact name: _____ Phone: _____

Relationship to patient: _____ 2nd ph # _____

Primary Insurance Co: _____ Insured: _____

Secondary Insurance Co: _____ Insured: _____

You will receive statements for balances due which are payable upon receipt. We are happy to assist you with account issues. If your account becomes delinquent & is referred to a 3rd party for collections, you are hereby responsible for all collection and/or attorney fees. All co-pays are due @ time of office visit. Thank you for giving us the opportunity to serve you.

Signature: _____ **Date** _____

Review of Symptoms	
Please check here if none of the following apply: <input type="checkbox"/>	
Constitutional:	<input type="checkbox"/> Fever/Chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexplained weight loss
Eyes:	<input type="checkbox"/> Recent change in vision
Cardiovascular:	<input type="checkbox"/> Heart attack or chest pain <input type="checkbox"/> Pain in legs with walking <input type="checkbox"/> History of stroke or TIA <input type="checkbox"/> History of cardiac cath <input type="checkbox"/> Heart Failure <input type="checkbox"/> Heart Palpitation <input type="checkbox"/> History of aneurysm
ENT:	<input type="checkbox"/> Hoarse voice <input type="checkbox"/> Sore throat <input type="checkbox"/> Sores/Lesions in mouth <input type="checkbox"/> Chronic/Persistent cough
Respiratory:	<input type="checkbox"/> Excessive shortness of breath <input type="checkbox"/> Emphysema or COPD <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Use home oxygen <input type="checkbox"/> Use CPAP or BIPAP
Gastrointestinal:	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Recent blood in stool <input type="checkbox"/> Heart Burn or recent regurgitation of food <input type="checkbox"/> History of vomiting blood <input type="checkbox"/> Colonoscopy
Genitourinary:	<input type="checkbox"/> Difficulty with urination <input type="checkbox"/> Incontinence
Musculoskeletal:	<input type="checkbox"/> Leg cramps <input type="checkbox"/> Joint Swelling
Skin/Breast:	<input type="checkbox"/> New skin lesions/moles <input type="checkbox"/> Breast mass <input type="checkbox"/> Nipple discharge
Neurological:	<input type="checkbox"/> History of seizures
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Other (please list)
Endocrine:	<input type="checkbox"/> Hot/Cold episodes <input type="checkbox"/> History of thyroid disease
Hematology/Lymphatic	<input type="checkbox"/> Bleeding abnormality <input type="checkbox"/> Any objections to a blood
Allergy/Immunology:	<input type="checkbox"/> Problems with anesthesia <input type="checkbox"/> Latex or tape allergy

Please list any other symptoms you are having in this area:

Family History	
Family History:	Family Relationship:
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Aneurysms	
Social History	
<i>Occupation:</i>	
<i>Marital Status:</i>	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered
<i>Tobacco use:</i>	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently (list packs/day and # of years)
<i>Alcohol:</i>	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily

The above is true and correct to the best of my knowledge. (Please sign below)

Signature _____ **Date** _____

PATIENT ACKNOWLEDGMENT FORM

Patient's Name: _____ SSN: _____ DOB: _____

I understand that the patient's health information is private and confidential. I understand that Drs. Jones, Engler, Hill & Associates, P.C. works very hard to protect patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Drs. Jones, Engler, Hill & Assoc., P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Drs. Jones, Engler, Hill & Assoc., P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and contains a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

Drs. Jones, Engler, Hill & Assoc., P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Drs. Jones, Engler, Hill & Assoc., P.C. will provide me with the most current "Notice of Privacy Practices".

Drs. Jones, Engler, Hill & Assoc., P.C. has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgments/authorizations; reasonable time frames for requests, charges for copies and non-routine information needs; etc. I will assist Drs. Jones, Engler, Hill, & Assoc., P.C. by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Drs. Jones, Engler, Hill & Assoc., PC's "Notice of Privacy Practices".

Signature: _____ Date: _____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

With this consent, Drs. Jones, Engler, Hill & Assoc., 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 treatment, payment, and operations such as appointment reminders, insurance items and calls pertaining to my clinical care, including tests results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Drs. Jones, Engler, Hill & Assoc., P.C. to release my protected health information to my family members both verbally and written, and to mail prescription, disability forms, etc. to me or my family members as needed.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature: _____ Date: _____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc)

Printed name of Patient and/or Personal Representative: _____

Drs. Jones, Hill, Blaney and Davis
2101 Central Ave.
Augusta, Ga. 30904

Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. If co-payment cannot be made at the time of service your appointment will be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account. We appreciate payment in full within 10 days. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through use of:
 - a. Payment with a credit card
 - b. Extension of a line of credit through a medical services credit company
 - c. Establishing a monthly payment contract with our office
3. Statements will be mailed to you monthly for outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia.
4. Prior to elective surgery we will confirm benefits and balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We appreciate payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing afterwards.
5. Questions or concerns regarding your bills should be addressed directly with the billing staff and not your physician.
6. We take pride in our relationship with you and appreciate you giving us the opportunity to care for you and your family. We understand that medical care can be costly and are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter.

Patient Signature