Lanier Family Healthcare

Gary Orris, MD *Kasin Anton, P.A.-C*

Patient Information Form

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE AND INSURANCE CARD BEFORE SEEING A DOCTOR

LAST NAME_____FIRST NAME_____M.I_____

NAME YOU PREFER TO GO BY _____

ADDRESS_____CITY_____

STATE_____ZIP_____HOME PHONE_____CELL PHONE _____

BIRTHDATE_____

EMAIL_____SSN____-____-_____

SEX (M) _____(F)_____ MARITAL STATUS: ○ S ○ M ○ W ○ D

REFERRED BY_____

EMERGENCY CONTACT_____PHONE_____

RELATIONSHIP TO THE PATIENT_____

IF PATIENT IS A MINOR, COMPLETE THE NEXT TWO LINES

FATHER'S NAME_____PHONE_____ DOB:_____

MOTHER'S NAME_____PHONE_____ DOB:_____

I HAVE PROVIDED THE OFFICE WITH A COPY OF THE FOLLOWING INFORMATION

PHOTO ID	Y ☐	N ☐	I AM SELF PAY	Y ☐	N ☐
INSURANCE CARD	Y ☐	N ☐	CURRENT CREDIT CARD	Y ☐	N ☐

The above information is accurate to the best of my knowledge. I authorize benefits for my services to be paid directly to Lanier Family Healthcare. I understand that it is my responsibility to verify my insurance benefits and coverage with my insurance. In the event my insurance(s) or other 3rd party does not cover service(s) provided to me, I will be financially responsible for those services along with any other deductible and/or co-insurance that may be applied. I also understand that if Lanier Family Healthcare ever can not verify my eligibility with my insurance, I will be treated as self-pay and will pay for my services at the time of my visit.

SIGNED: _____ DATE:_____

COLLECTION AGENCY FEES:
I understand that if I do not pay my balance in full within 30 days of receiving notice of any outstanding balance my account may be subject to being referred to an outside collection agency. Should this happen, I understand that I will also be responsible for an additional fee of 30% of the dollar amount that is submitted to the collection agency.

SIGNED: _____ DATE:_____

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Patient Current Visit

Patient Name_____ Date of Birth_____

What medical concerns can we assist with today? _____

Current Medications:

Medications	Dose (mg/mcg)	Number of times a day

Are you allergic to any medications? ☐ Yes ☐ No

If yes, to which medications? _____

Social History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how many packs per day? _____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No

If yes, how many drinks per week? _____

Do you currently drink coffee, soda, tea, or energy drinks? ☐ Yes ☐ No

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seatbelts when driving? ☐ Yes ☐ No

Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Have you have had any of these symptoms: (Please check):

- ☐ Cough
- ☐ Change in Vision
- ☐ Sinus pain
- ☐ Leg cramps
- ☐ Bloody nose
- ☐ Swollen/painful joints
- ☐ Allergy symptoms
- ☐ Heartburn
- ☐ Thoughts of suicide
- ☐ Headache
- ☐ Breathing problems
- ☐ Diarrhea
- ☐ Eye pain/runny eyes
- ☐ Dizziness
- ☐ Chest pain
- ☐ Vomiting
- ☐ Decreased hearing
- ☐ Fainting
- ☐ Palpitations
- ☐ Rash
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Pain with urination
- ☐ Urinating frequently
- ☐ Back pain
- ☐ Foot/ankle pain
- ☐ Nerve pain
- ☐ Trouble sleeping/snoring
- ☐ Sore Throat
- ☐ Swollen lymph nodes

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Past Medical History

Patient Name_____ Date of Birth_____

Immunizations (Enter dates if known)

Gardasil
Hepatitis A
Hepatitis B
Influenza (FLU)
Measles (MMR)
Meningitis
Polio
Pneumonia
Shingles
Tetanus
Typhoid

Which of the following conditions are you currently being treated or have been treated for in the past? (Please check the box)

- ☐ High cholesterol
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Lung Problems/cough
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Tonsillitis
- ☐ Ear problems
- ☐ Kidney/bladder problems
- ☐ Cancer
- ☐ Sexually transmitted disease
- ☐ Hearing loss
- ☐ Kidney stones
- ☐ Eye disorder/glaucoma
- ☐ Seizures
- ☐ Stroke
- ☐ Headaches/migraines
- ☐ Neurological problems
- ☐ Depression/anxiety
- ☐ Psychiatric care
- ☐ Liver problems/hepatitis
- ☐ Ulcers/colitis
- ☐ Prostate problems
- ☐ Rheumatic fever
- ☐ Eating disorder
- ☐ Swollen ankles/vein problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid problems
- ☐ Corrective lenses/glasses
- ☐ Hernia
- ☐ Bruising
- ☐ Trouble sleeping
- ☐ Changes in skin
- ☐ Hair loss
- ☐ Heart Murmur/Angina
- ☐ OTHER: _____

Past Diagnostic studies and health maintenance: Have you ever had and when.

- ☐ Any CT scan
- ☐ Stress test
- ☐ Colonoscopy
- ☐ Any MRI scans
- ☐ Ultrasounds
- ☐ Endoscopy
- ☐ Bone Density
- ☐ Prostate check (male)
- ☐ Eye exam

Please describe any current or past medical treatment not listed above:

_____

Have you ever been hospitalized overnight? ☐ **Yes** ☐ **No**

Please list your past surgeries and year the surgery was performed:

Surgery:_____ Year:_____ Surgery:_____ Year:_____

Surgery:_____ Year:_____ Surgery:_____ Year:_____

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Family History

Patient Name_____ Date of Birth_____

Please list the members of your family (including children and parents) that have had any treatable conditions

Family Members	Living	Age /Age if deceased	Medical Condition(s)
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			
Grandmother			
Grandfather			

Females: Gynecological History:

First day of your last menstrual period?_____

How many times have you been pregnant? _____ outcome?_____

Date of last Pap smear: _____

Have you had an abnormal Pap smear? ☐ Yes ☐ No

Date of last mammogram: _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

Pharmacy that you want to use: _____

City_____ Phone# _____

5830 Bond Street, Suite 200, Cumming GA 30040 Phone: (770) 205-5518 Fax: (770) 205-5519
www.LanierFamilyHealthcare.com info@lfhllc.com

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PAIN MEDICINE POLICY

- I agree to take narcotic medication exactly as instructed. I am not allowed to change dosage amounts or alter the time schedule of taking the medication without talking to my prescribing physician.
- Narcotics WILL NOT be phoned in you MUST come to the office to pick up a written prescription.
- Only ONE pharmacy will be used for filling narcotic prescriptions.
- You will take controlled medications EXACTLY as prescribed.
- The following are conditions for IMMEDIATE termination from the practice:
- Obtaining narcotics from ANY other physician while under our care without our knowledge.
- Altering or forging of a prescription is a felony and will be reported.
- Patients may be terminated from the practice with 30-day notice for noncompliance in the taking of their medication.
- We will NOT refill prescriptions that have been lost or misplaced. Please be responsible for keeping up with your narcotic prescription.
- Stolen medications will be replaced ONCE and ONLY if you have a valid police report.
- In the case of intolerance or ineffective narcotic medications, a different prescription could be given, provided the unused portion of the previously prescribed medication is returned.
- I am aware that most of the manufactures of drugs used to treat chronic pain recommended AGAINST the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
- I will NOT combine any narcotic medications with the consumption of alcohol.
- I will NOT give, trade, or sell any pain medication.
- I will allow 24 hours for prescription refills to be authorized.
- A drug screen might be performed at your office visit without notice.

I have read and understand the above policy and agree to abide by its terms.

Patient Signature:_____ Date:_____

Patient Name: _____

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Authorization to release information to Family Member or Friend

I, _____, am authorizing Lanier Family Healthcare
(Patient's Name)

to release any of my medical information to _____, if they
(Family Member/Friend Name)

should call or write on my behalf. This authorization is effective _____
(start date)

and will not expire until further notice in writing.

Signature_____ Date_____
(Patient's Signature)

OPT to Decline _____

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