Fields' Family Care

96 Tara Commons Drive · Loganville, GA 30052
770-554-0399

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Place of Birth: _____

City, State, ZIP: _____ Social Security #: _____

Primary Phone: (_____) _____ Race: _____ Sex: Male Female

Secondary Phone: (_____) _____ Marital Status: Married Single Divorced Widowed

Mailing address: _____ Email: _____

How did you hear about this practice? _____

Family Members in Household:

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Emergency Contact:

Name: _____ Date of birth: _____

Relation: _____ Phone: _____

Primary Insurance Company: _____ Phone: (_____) _____

Claims Address: _____

Identification #: _____ Group #: _____

Name of person who holds this policy: _____ Relationship: _____

Policy holder's SSN: _____ DOB: _____

Secondary Insurance Company: _____ Phone: (_____) _____

Claims Address: _____

Identification #: _____ Group #: _____

Name of person who holds this policy: _____ Relationship: _____

Policy holder's SSN: _____ DOB: _____

Signature: _____ Date: ____/____/____

Patient / Patient Guardian

Fields' Family Care

FORMS MUST BE SIGNED & DATED

Medical History: Name: _____ Birthdate: ____/____/_____

Allergies to Medications, X-Ray Dyes, or Other Substances? ☐ No ☐ Yes

(If yes, please list the name of the substance): _____

Family History:

➢ Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family member(s)?	Approximate age diagnosed
Thyroid:	_____	_____
Cancer (describe type):	_____	_____
Diabetes:	_____	_____
High Cholesterol:	_____	_____
Heart Disease:	_____	_____
Strokes:	_____	_____
Hypertension (high blood pressure):	_____	_____
Mental Illness (depression, anxiety, etc.):	_____	_____
Drug or Alcohol Addiction:	_____	_____

Patient Information:

Past Surgeries, Accidents, or Other History: _____

Circle your answers

Tobacco use: None Cigarettes Cigars Pipes Chewing Tobacco

Current use OR Previous use How long? _____ Amount per day? _____

Alcohol use: None Beer Wine liquor

Current use OR Previous use How often? _____ How much? _____

Caffeine use: None Soda Coffee Tea How often? _____ How much? _____

Current Medications (include name, strength, and dose): _____

RX & OTC

_____

Present Medical Condition / Review of Systems:

Circle Yes or No

Blood or bleeding disorders:	Yes No	Heart Disease:	Yes No	Mental Illness:	Yes No
Cancer:	Yes No	Hypertension:	Yes No	Respiratory disorders:	Yes No
Diabetes:	Yes No	Joint pain:	Yes No	Skin Disorder:	Yes No
Drug or alcohol addiction:	Yes No	Kidney Disease:	Yes No	Thyroid disorder:	Yes No
Gastrointestinal disorders:	Yes No	Liver Disease:	Yes No	Venereal Disease:	Yes No
Glaucoma – cataracts, etc.:	Yes No	Lower back pain:	Yes No	Other: _____	

Signature: _____ Date: ____/____/____

Patient / Patient Guardian

Fields' Family Care

96 Tara Commons Dr, Loganville, GA 30052

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTATION

Patient Name: _____ DOB: _____

I, the undersigned, **authorize permission** for David A. Fields, MD, Family Care, PC to be able to discuss my medical health information with the following individuals (family members or friends):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Pharmacies for today's RX:

(Local) _____

(Mail Order) _____

I authorize Dr. David A. Fields' office to send un-encrypted emails to me, upon my request:

Email: _____

How would you like to receive appointment reminders? (Check one)

_____ Text _____ Call _____ Email

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for my healthcare related utilization review or quality assurance activities. I hereby assign and authorize payment to David A. Fields, MD, Family Care PC, of all medical and/or surgical benefits, including major medical benefits to which I am entitled to under any insurance policy or policies, under and self-insurance program, or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to David A. Fields, MD, Family Care PC, by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered effective and valid as the original. I understand that I have the right to receive a copy of this authorization. **I understand that an increase of 40% shall be added to any balance that is turned over to a collection agency. I understand that I will be charged a $25 fee for No Shows on appointments scheduled.** I, the undersigned, have had the opportunity to review a copy of David A. Fields, MD, Family Care, PC's Notice of Privacy Practices.

Signature: _____ Date: ____/____/____

Patient / Patient Guardian