David L. Anders, M.D.

Kedron Medical Offices • 101 McWilliams Drive • Peachtree City, Georgia 30269

Please PRINT Carefully		**Patient Registration and Annual Update**
Patient's Last Name	First Name	Middle Name
Date of Birth	Social Security Number	Sex ☐ Male ☐Female
Street Address or Post Office Box		
City	State	Zip Code
Home phone	Work phone	
Name of Patient's Employer	Employer's Address	
☐ Full time 1 ☐ Part time 2 ☐ Self employed 4 ☐ Retired 5 ☐ Not currently employed 3		
Marital status ☐ Single s ☐ Married m ☐ Divorced d ☐ Widowed w ☐ Separated x		
Spouse's Name	Spouse's Daytime Phone	
In case of emergency, contact ☐Spouse as listed above ☐See next two lines		
Emergency Contact's Name		
Relationship to Patient	Contact's Daytime Telephone	
Name of Person Responsible for Payment		
Primary Insurance Information – Please present your card if you would like us to file for you.		
Primary Insurance Company	Policy Holder ☐Self01 ☐Spouse02 ☐Parent03	
Policy Holder's Name ☐Same as patient information above ☐See next two lines		
Last Name	First	Middle
Policy Holder's Date of Birth	Policy Holder's Social Security Number	Policy Holder's Employer

Medical Treatment Permit I give permission for medical diagnosis, treatment and testing as may be deemed advisable or necessary by David L. Anders, M.D.	**Initials**
Authorization to Release Information Dr. Anders and staff are authorized to disclose all or any part of my medical record. This may include psychiatric, psychological, infectious, contagious disease (including AIDS), and alcohol abuse information to any or all insurance company(ies) providing coverage to me, to any employer if insurance coverage is provided under a group plan, and to any hospital or medical personnel for use in my care. This authorization remains valid unless otherwise revoked by me in writing.	**Initials**
Payment of Benefits and Right of Recovery I authorize the insurance company(ies) listed to pay directly to David L. Anders, MD PC all benefits due under said policy(ies). I am responsible to pay for non-covered services.	**Initials**

Today's Date	**Signature of Patient**

MR #

David L. Anders, M.D., P.C.
101 McWilliams Drive*Peachtree City, Georgia 30269
770-487-0808

CONSENT TO PAYMENT FOR SERVICES RENDERED

THE UNDERSIGNED UNDERSTANDS THAT THE PATIENT'S INSURANCE COMPANY OR OTHER THIRD-PARTY PAYOR MAY DENY PAYMENT FOR PART OR ALL OF THE CHARGES FOR MEDICAL SERVICES RENDERED TO THE PATIENT WHOSE NAME APPEARS BELOW. SUCH DENIALS MAY OCCUR AFTER THE DATE OF SERVICE ON THE GROUNDS THAT SUCH MEDICAL SERVICES AND SUPPLIES WERE DEEMED TO BE NOT MEDICALLY NECESSARY OR WERE NOT COVERED SERVICES UNDER THE PATIENTS AGREEMENT WITH THEIR INSURANCE COMPANY, REGARDLESS OF THE FACT THAT THE PATIENT'S PHYSICIAN ORDERED THE SERVICES AND BELIEVED THEM TO BE MEDICALLY NECESSARY. THE UNDERSIGNED HEREBY AGREES TO REIMBURSE THE PHYSICIAN DIRECTLY FOR ANY AND ALL MEDICAL SERVICES AND SUPPLIES DETERMINED BY THE PATIENT'S INSURANCE COMPANY AS NOT BEING MEDICALLY NECESSARY OR NOT COVERED.

IF THE PATIENT'S INSURANCE COMPANY HAS NOT PAID WITHIN THIRTY (30) DAYS FROM THE DATE OF BILLING, THE PATIENT IS RESPONSIBLE TO CONTACT THEIR INSURANCE COMPANY FOR PAYMENT. BALANCES OWED AFTER INSURANCE PAYMENT ARE DUE AND PAYABLE, IN FULL, WITHIN THIRTY (30) DAYS UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE THROUGH THE OFFICE. FOR PATIENTS WITHOUT INSURANCE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. ARRANGEMENTS TO MAKE PAYMENTS ON BALANCES DUE MAY BE MADE WITH THE OFFICE.

PLEASE NOTE: INSURANCE. THE PATIENT/GUARANTOR IS STILL RESPONSIBLE FOR ALL CHARGES AND PAYMENTS. MEDICARE PATIENTS ARE ELIGIBLE FOR COMPLIMENTARY MEDICARE SECONDARY ELECTRONIC CROSSOVER FILING, WHICH IS SET UP BY THE PATIENT THROUGH THEIR SECONDARY INSURANCE. THIS ALLOWS MEDICARE TO FILE YOUR CLAIM DIRECTLY TO YOUR SECONDARY INSURANCE.

ALL PATIENTS MUST PRESENT CURRENT INSURANCE CARDS WITH CORRECT ID NUMBERS AND CLAIMS INFORMATION. ALL PATIENTS WILL BE ASKED TO PAY ALL DEDUCTIBLES, COINSURANCE AND NON-COVERED CHARGES THAT MAY BE DUE AT THE TIME OF SERVICE. COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

TO ASSIST OUR PATIENTS IN PAYING FOR SERVICES RENDERED, WE ACCEPT CASH, CHECKS OR UNITED STATES POSTAL SERVICE MONEY ORDERS, AND CREDIT CARDS. IN THE EVENT OF DEFAULT, THE PATIENT UNDERSTANDS THEY ARE RESPONSIBLE FOR REASONABLE COLLECTION COST AND/OR ATTORNEY'S FEES.

THE UNDERSIGNED HAS READ AND RECEIVED A COPY OF THIS FORM AND CERTIFIES THAT THEY ARE THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE OR ARE DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THIS CONSENT TO PAYMENT FOR SERVICES AND ACCEPTS THESE TERMS.

____ DATE: ___________
SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR
If signed by other than the patient, please indicate relationship: _______________
WITNESS: ___________________________________
If the patient or patient's representative refused to sign, the notation, "Patient Refuses to Sign" should by made in the space for the patient's signature.

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Peachtree City, Georgia 30269

CONSENT TO PARTICIPATION IN PATIENT PORTAL

We offer a patient portal to provide a self-service option for you to view your healthcare information. (Access to a patient portal through which you can view healthcare information is **required by Medicare**. Visit www.HealthIT.gov for more information.) Information accessible through the patient portal includes, but is not limited to: demographics, reason for visit, medications, allergies, vital signs, procedures done during the visit, clinical instructions, immunization records, lab test results, and a personal plan of care.

Should you choose to download, copy, distribute, or save your healthcare information available within the patient portal, David L. Anders, M.D., P.C. cannot be held liable for any resulting breach of confidentiality. Please do not give your password to anyone, and we recommend that you change the password from the password automatically generated for you at the time of your portal's creation. While we make every effort to protect your personal information, we cannot ensure or guarantee the security of any information you transmit to us. No data transmission over the Internet or any wireless network can be guaranteed to be perfectly secure. If you use our patient portal, you are responsible for maintaining the confidentiality of your account and its password, and for restricting access to your computer. Our staff will ***never*** ask for your password in an unsolicited phone call or in an unsolicited email. Remember to sign out of your account and close your browser window when you leave the portal. By signing below and providing your personal email address, you accept responsibility for any actions that occur under your account. David L. Anders M.D., P.C. reserves the right to refuse service, terminate portal accounts, or remove or edit portal contents.

An added benefit of the patient portal is that by providing your email address, home phone, or cell phone, you consent to receive communications from us electronically. We will use this information to automatically remind you of upcoming appointments and communicate with you about documents posted to the portal. Most notably, we will use your email address to generate a patient portal for you, at which point you will receive an email detailing the set up process of your portal account. Please notify our staff if you cannot access the patient portal.

NAME:	DATE OF BIRTH:
EMAIL ADDRESS: *(Required)*	Please rank preference for future contact. 1 2 3
HOME PHONE:	1 2 3
CELL PHONE:	1 2 3

____ DATE: __________________
SIGNATURE OF PATIENT/GUARDIAN/GUARANTOR

____ I hereby elect NOT to participate in the patient portal.

David L. Anders, M.D., P.C.• Internal Medicine & Geriatrics • 101 McWilliams Drive • Peachtree City, GA 30269 • 770-487-0808

Comprehensive Medical Record

Name____ Date_____________________

Your past medical history plays an important role in determining your future health and health-related decisions. A review of risk factors may also identify areas which merit special concern.

Please answer the following questions to the best of your ability. If you find questions which you are uncertain about or do not understand, leave them unanswered.

Date of Birth__________________________

In a sentence or two, explain the reason for today's examination:

When was your last complete physical examination? ________________ By whom?_______________________

MEDICATIONS: If no medications are currently used, check here_______. Otherwise, list all medications (prescription or over-the counter) currently or regularly used (continue on reverse if necessary):

Name of Drug	Dosage Size	Frequency of Use	Date Started	Why Taken (Indication)

ALLERGIES: Check if no allergies to medications___ OR list all medication allergies, and the type of allergic symptoms:

Medication	Symptoms	Medication	Symptoms

20170222

Name____ Date________________________

MEDICAL CONDITIONS: Place a check (and approximate **year diagnosed** if known) beside any of the conditions listed below for which you have already been diagnosed by a doctor:

_________ anxiety
_________ vitamin B-12 deficiency
_________ obesity
_________ enlarged prostate
_________ coronary artery disease, heart attack, angina
_________ high cholesterol
_________ degenerative disc disease
_________ depression
_________ osteoarthritis
_________ diabetes
_________ heartburn
_________ impotence (“E.D.”)
_________ gastroesophageal reflux disease (“GERD”)
_________ hypertension (“high blood pressure”)
_________ high triglycerides
_________ hypothyroidism (“low thyroid”)
_________ insomnia
_________ osteopenia
_________ osteoporosis
_________ sleep apnea
_________ allergic rhinitis
_________ chronic rhinitis
_________ atrial fibrillation
_________ Alzheimer's disease
_________ asthma
_________ cancer: type(s)_____________________
_________ carpal tunnel syndrome
_________ colon polyp
_________ chronic obstructive lung disease/COPD
_________ stroke
_________ gout
_________ hearing loss requiring hearing aid
_________ hemorrhoids
_________ deep vein thrombosis (blood clots in legs)
_________ migraine headache
_________ macular degeneration
_________ over-active bladder
_________ Parkinson's Disease
_________ psoriasis
_________ seizure
_________ shingles/herpes zoster virus
_________ vertigo

SURGERIES: Place a check (and approximate **year performed** if known) beside any of the surgeries listed below which you have had:

_________ appendectomy
_________ bariatric/weight-loss surgery
_________ bladder repair/ incontinence surgery
_________ breast augmentation
_________ breast biopsy of benign mass ___ lft ___rt
_________ bilateral tubal ligation
_________ C-section
_________ coronary artery bypass grafting
_________ coronary artery stent
_________ cataract removal ___ left; ___right
_________ carotid artery blockage
_________ cervical spine repair surgery
_________ gallbladder removed
_________ lithotripsy or kidney stone surgery
_________ esophageal dilation
_________ fracture with surgical repair: __________
_________ hip replacement ___ left; ___right
_________ hysterectomy ___ with cancer; ___no CA
_________ groin hernia repair ___ left; ___right
_________ knee replacement ___ left; ___right
_________ lumbar spine repair surgery
_________ mastectomy ___ left; ___right
_________ melanoma removal
_________ non-melanoma skin cancer removal
_________ pacemaker inserted
_________ prostate removal (complete)
_________ thyroid removal
_________ tonsillectomy
_________ transurethral resection of the prostate
_________ umbilical “belly button” hernia repair
_________ vein stripping

List any other significant injuries, medical or surgical disorders which have been treated or diagnosed:

PREVENTION: List the last date (if ever) you had the following tests or immunizations:

Procedure	**Date (Year)**	**Procedure**	**Date (Year)**
Colonoscopy	__________	Mammogram	__________
Flu vaccination	__________	Blood cholesterol	__________
Tdap (tetanus/diphtheria)	__________	Blood glucose (sugar)	__________
Tetanus vaccination	__________	PAP smear	__________
Prevnar-13 (pneumonia)	__________	Chest X-ray	__________
Pneumonia vax-23	__________	TB skin test	__________
Zostavax (shingles vax)	__________	Prostate (PSA) blood test	__________

FAMILY HISTORY: To learn more about your family medical history, have any first-degree relatives (parents, siblings, children) had the following: (If you do not know your family medical history, check here: ____)

Illness	No	Yes	If yes, what relative and **at what age** was the condition diagnosed?
Heart attack or blockages	___	___	____
Diabetes	___	___	____
Breast cancer	___	___	____
Colon cancer	___	___	____
Prostate cancer	___	___	____
Other cancer	___	___	____
Stroke	___	___	____
Thyroid disease	___	___	____
Severe depression	___	___	____
High blood pressure	___	___	____
High cholesterol	___	___	____
Alzheimer’s Disease	___	___	____

Other significant Family History:

LIFESTYLE, ETC.: Please answer the following questions pertaining to your social history, habits, and lifestyle:

In an average week, **how many** of the following alcoholic beverages will you drink?

___ None/NA
___ 12 ounce beer
___ 4 ounce wine
___ 1 ounce liquor

What is your marital status?

___ single
___ married
___ separated
___ divorced
___ widowed

If you are/were employed, what is/was your occupation? ________________________ Are you retired? ___Yes ___No

Do you have any reason to feel you may have been exposed to the AIDS virus? ___Yes ___No

Do you regularly wear a seat belt? ___Yes ___No

List any foods or types of foods you attempt to avoid in your regular daily meals:

____.

On a scale of "1 (low) to 10", how healthy is your diet? ______

For the tobacco products listed below, please indicate whether you have ever been a regular user of each product, and the year started (and quit, if applicable) and the daily amount used:

Product	Never used	Former user	Current user	Year started	Year Quit	Daily amount used
Cigarettes	_________	_________	_________	__________	__________	________________
Pipe	_________	_________	_________	__________	__________	________________
Cigars	_________	_________	_________	__________	__________	________________
Smokeless	_________	_________	_________	__________	__________	________________

If you currently use a tobacco product, are you interested in quitting? ___Yes ___No

Do you wear glasses or contact lenses? ___Yes ___No

Do you wear dentures? ___Yes ___No

When was your last eye exam? ____________________________

When was your last dental exam? ____________________________

On a scale of "1 (low) to 10", how much stress are you under? ______

Do you manage this level of stress well? ___Yes ___No

Describe any routine exercise activity, including the type of activity, frequency and duration or distance:

____

Name____ Date______________________

SYMPTOMS: Please check "yes" for symptoms you have had during the past 12 months. Check "no" if you have not had a symptom. If you are uncertain, do not check either box, or use a question mark.

Symptom	No	Yes
GENERAL		
unintentional weight loss	____	____
unintentional weight gain	____	____
fevers	____	____
chills	____	____
night sweats	____	____
excessive fatigue	____	____
SKIN		
itching	____	____
change in moles	____	____
rashes	____	____
tumors	____	____
unexplained change in hair	____	____
HEMATOLOGIC		
easy bruising	____	____
anemia	____	____
abnormal bleeding	____	____
NEUROLOGIC		
headaches	____	____
fainting	____	____
dizziness	____	____
seizures	____	____
muscle weakness	____	____
numbness	____	____
double vision	____	____
blurred vision	____	____
failing memory	____	____
EARS, NOSE, MOUTH		
ringing in ears	____	____
decreased hearing	____	____
recurrent nose bleeds	____	____
recurrent sinus infection	____	____
frequent runny nose	____	____
persistent hoarseness	____	____
lumps or knots in neck	____	____
CARDIOPULMONARY		
recurrent cough	____	____
sputum production	____	____
shortness of breath	____	____
wheezing	____	____
coughing up blood	____	____
chest pain with exercise	____	____

Symptom	No	Yes
chest pain at rest	____	____
use of more than one pillow	____	____
ankle swelling	____	____
skipped/fluttering heart beats	____	____
inflammation of leg veins	____	____
GASTROINTESTINAL		
recurrent nausea	____	____
recurrent vomiting	____	____
recurrent diarrhea	____	____
constipation	____	____
blood in stool	____	____
vomiting blood	____	____
black stools	____	____
difficulty swallowing	____	____
abdominal pain	____	____
use of antacids	____	____
GENITOURINARY		
recurrent bladder infection	____	____
pain with urination	____	____
blood in urine	____	____
pus in urine	____	____
urinate too frequently	____	____
difficulty starting urine	____	____
urgency to urinate	____	____
loss of urine/wetting self	____	____
urination twice or more at night	____	____
MUSCULOSKELETAL		
joint pain	____	____
joint swelling	____	____
recurrent muscle aches	____	____
falling	____	____
use of a cane	____	____
use of a walker or wheelchair	____	____
ENDOCRINOLOGIC		
heat intolerance	____	____
cold intolerance	____	____
increased thirst	____	____
PSYCHIATRIC		
anxiety/nervousness	____	____
insomnia	____	____
depression	____	____
grief	____	____