Primary Care Clinics of Georgia, LLC

Patient Registration

Please Print.

Date: ______________________________

Name: ____
First Middle Last

Home Address: ____

____
City State Zip Code

Home Phone # ____________________ Social Security # ____________________

Sex: Male Female Date of Birth: ________________ Marital Status: ____________

Employer: ________________________________ Work Phone # __________________

Address: ________________________________

____

If the patient is a minor, please complete this section:

Responsible Guardian: ______________________________ Social Security # ______________

Address: ______________________________

____
City State Zip Code

Employer: ______________________________ Work Phone # ________________

____
City State Zip Code

In case of emergency we should contact:

Name: ______________________________ Relationship: ____________________
First Middle Last

Employer: ______________________________ Phone # ______________________

I authorize Primary Care Clinics of Georgia, LLC to disclose any and all of my records to my insurance carrier in order for Primary Care Clinics of Georgia, LLC to receive payment of services rendered. I understand that I am responsible for full payment of services rendered to me.

______________________________________ ______________________
Patient's Signature (guardian of minor child) Date

Guarantor Information:

Primary Insurance:

Patient Name: ______________________ Patient Date of Birth: ____________

Subscriber Name: ______________________ Subscriber Date of Birth: ____________

Subscriber Social Security Number: ________________

Name of Insurance Company: ____

Address of Insurance Company: ____

____
City State Zip Code

Member Identification Number: ____

Group Number ____

Effective Date of Coverage: ____

Secondary Insurance:

Patient Name: ______________________ Patient Date of Birth: ____________

Subscriber Name: ______________________ Subscriber Date of Birth: ____________

Subscriber Social Security Number: ________________

Name of Insurance Company: ____

Address of Insurance Company: ____

____
City State Zip Code

Member Identification Number: ____

Group Number ____

Effective Date of Coverage: ____

I authorize Primary Care Clinics of Georgia, LLC to disclose any and all of my records to my insurance carrier in order for Primary Care Clinics, LLC to receive payment of services rendered. I understand that I am responsible for full payment of services rendered to me.

________________________________ ________________
Patient's Signature (guardian of minor child) Date

Primary Care Clinics of Georgia, LLC
Medical History

This information is to be used by our physicians as part of your confidential medical record.

Please Print.

Name: ______________________________ Date: ______________
First Middle Last

Social Security # ______________ Date of Birth: ______________

Allergies to Medications, Xray Dyes, or Other Substances: Yes ______ No ______
If "yes", please list medications and types of reactions:

Medication: ______________ Reaction: ______________

Medication: ______________ Reaction: ______________

Past Medical History and Review of Systems:
Please circle if you have had problems with or are presently experiencing any of the following:

High Blood Pressure	Bronchitis	Change in Bowel Habits
Diabetes	Pneumonia	Unexplained Weight Gain/Loss
Cancer	Persistent Cough	Hemorrhoids
Heart Disease	Tuberculosis	Gallbladder Disease
Chest Pain/Chest Tightness	Hay Fever	Colitis
Shortness of Breath	Abdominal Discomfort	Hepatitis or Jaundice
Swollen Ankles	Indigestion	Thyroid Disease
Palpitations	Nausea	Head or Neck Radiation
Lightheadedness	Vomiting	Headache
Frequent Urination	Constipation	Kidney Disease
Rheumatic Fever	Diarrhea	Kidney Stones
Asthma	Blood in Stool	Difficulty Urinating
Ulcers	Arthritis	Low Back Problems
Skin Disease	Blood Disorders	Venereal Disease
Anxiety	Depression	Anemia
Alcohol Abuse	Drug Abuse	Gout

Other: ______________________________

Gynecologic and Obstetric History:

Age at onset of menstruation: ________ Frequency: ________ Length: ______ days
Pregnancies: ________ Births: ________ Miscarriages: ________
Prolonged or abnormal bleeding: Yes _____ No _____
Leakage of Urine Yes _____ No _____
Pelvic Pain Yes _____ No _____
Abnormal Discharge Yes _____ No _____
Abnormal Pap Smear Yes _____ No _____

Please List and Supply the Dates of:

Operations: ______________________________

____

Hospitalizations other than for operations: ______________________________

____

Immunization History -

Hepatitis B	Yes ____	No ____	Date: ________
Pneumovax	Yes ____	No ____	Date: ________
Flu Vaccine	Yes ____	No ____	Date: ________
Tetanus	Yes ____	No ____	Date: ________
Other ____	Yes ____	No ____	Date: ________

Date of most recent:

Pap Smear: ________ Breast Exam: ________

Prostrate Exam: ________ Cholesterol Check: ________

Stool Check for blood: ________

Family History

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

Illness	Family Member	Age When Diagnosed
Cancer, type ________		
High Blood Pressure		
Diabetes		
Strokes		
Depression, anxiety		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Disease		
Other ________		

Medications (Prescription, Over-the-counter, Vitamins, Herbs, etc.)

Drug Name	Dosage	Drug Name	Dosage

Prevention

Do you exercise daily?	Yes ____	No ____
Do you smoke?	Yes ____	No ____
Do you drink alcoholic beverages?	Yes ____	No ____
Do you drink caffeinated beverages?	Yes ____	No ____
Do you wish to be tested for AIDS?	Yes ____	No ____
Do you have a "living will"?	Yes ____	No ____
Do you have a "donor card"?	Yes ____	No ____

I understand that this information is to be used for my medical care and will remain confidential.

______________________________ ________

Patient's Signature (guardian of minor child) Date

Primary Care Clinics of Georgia
David L Hocker, MD, MRO
1990 Limestone Circle #100
Gainesville, GA 30501
(770) 536-1004

Patient Information Sheet

Name: Title ____ First ________________ Middle _____ Last ____________________ Suffix _____

AKA Name: First ______________________ Last ____________________________

Date of Birth: ___________________ Gender: Male Female

Race:
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islands
- Refuse to report
- White

Ethnicity:
- Hispanic or Latino
- Non Hispanic or Latino
- Refuse to Report

Language:
- English
- French
- German
- Japanese
- Mandarin
- Russian
- Spanish

Dominant Hand: Right Left

Primary Address: ____

____

Contact Information:

Phone ________________________ home ___________________________ cell

________________________ work ___________________________ other

Email: _______________________________________

Pharmacy Name: ____ Phone: _______________________

Pharmacy Address: _____________________________________

PRIMARY CARE CLINICS OF GEORGIA
DAVID L. HOCKER, MD, MRO
1990 Limestone Circle #100
GAINESVILLE, GA 30501
PHONE: (770) 536-1004 FAX: (770) 536-0905

E-Prescribing Consent Form

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Primary Care Clinics of Georgia** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to **Primary Care Clinics of Georgia** to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

______________________ ______________________
Print Patient Name **Patient Date of Birth**

______________________ ______________________
Signature of Patient or Guardian **Date**

____
Relationship to Patient

PRIMARY CARE CLINICS OF GEORGIA
DAVID L. HOCKER, MD, MRO
1990 Limestone Circle, #100
GAINESVILLE, GA 30501
PHONE: (770) 536-1004 FAX: (770) 536-0905

New Patient Information

1. **Call in requests for prescriptions/medication refills**

    - **A nurse will notify you if an office visit is required.**
    - **Check with your pharmacy after 5pm for your prescription.**
    - **Call in/refill requests made after 2pm will most likely be phoned in the next business day.**

2. **After Hours Care**

    - **Primary Care Clinics of Georgia/Dr. Hocker, is an ambulatory care clinic. This means that after hours care is not available.**
    - **Should you need to speak with or see a physician after hours, we recommend either Guilford Immediate Care or Northeast Georgia Urgent Care aka Quick Care.**

3. **Hospital Admissions**

    - **Should you require admission to the Hospital, a Hospitalist (a physician that only works in the hospital) from the Longstreet Clinic will admit and treat you while in the hospital @ Northeast Georgia Medical Center.**
    - **Once you have been released from the hospital, a follow up appointment with Dr. Hocker will be scheduled.**

PRIMARY CARE CLINICS OG GEORGIA
1990 LIMESTONE CIRCLE STE 100
GAINESVILLE GA 30501
PHONE: 770-536-1004 FAX: 770-536-0905

PATIENT INFORMATION

We will be charging a $10.00 fee for weight checks, blood pressure checks, or injections (you must bring in your medication).

All fast-track lab draws will be charged a nurse visit fee. This will apply to your copay if your insurance has one. If you have a deductible, you will be required to pay a minimum of $100.00 until your deductible has been met.

All copays must be paid at the time of our visit. If you have a deductible, you must pay $100.00 up front and any balance until the deductible is met.

If you are unable to pay you copay, deductible, or balance amounts you will be asked to reschedule your appointment.

All no-show appointments will be charged a $50.00 fee. You must call our office within 24 hours to cancel your appointment, or you will be charged this fee.

All forms that must be filled out by the physician will be charged a $25.00 fee.

All prescriptions will be called in throughout the day. If you call after 2:00pm it will not be available or called in until the following day.

Patient name: ____ DOB: ____/____/____

Patient signature: ____

Today's date: ____/____/____

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DAVID L. HOCKER, MD, MRO
1990 LIMESTONE CIRCLE, SUITE 100
GAINESVILLE, GA 30501
PHONE: (770) 536-1004 FAX: (770) 536-0905

Opiate Policy – New Patients

Primary Care Clinics of Georgia is an Opiate Free practice.

Dr. Hocker will not continue prescribing or prescribe any new opiates (pain pills, or sedatives) in this clinic.

All new patients must agree to and sign this opiate policy.

______________________ ______________________

Patient Signature **PCCG Staff Member**

Date:______________________________

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Primary Care Clinics of Georgia (PCCOG), LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing the consent. PCCOG reserves the right to revise its Notice of Privacy Practices at any time. A copy of Privacy Practices may be obtained by forwarding a written request to Cynthia Bagwell, 1990 Limestone Circle Suite 100 Gainesville GA 30501.

With this consent, PCCOG may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, cards, and patient statements as long as they are marked "Confidential."

I have the right to request that PCCOG restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PCCOG to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except the extent that the practice has already made disclosures in reliance upon my prior consent, or later revoke it, PCCOG may decline to provide treat to me.

Signed by: ______________________________ Date: _____/_____/_____
Signature of Patient of Legal Guardian

______________________________ ______________________________
Print Patient's Name Print Name Legal Guardian

The following person(S) is allowed to receive PHI (protective health information); this includes test results, and prescriptions:

______________________________ ______________________________

______________________________ ______________________________

Signed by: ______________________________ Date: ______________________
Signature of patient or Legal Guardian

*Failure to list anyone on this form will require that I personally pick up my PHI.