

VERANET HEALTH CARE, LLC/WOMENS CARE OF WEST GEORGIA, LLC

403 Permian Way, Suite A
Villa Rica, GA 30180
Phone 770-771-5235

Patient Information Sheet

Date _____

NAME: LAST _____ FIRST _____ MIDDLE INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EXT. _____

PRIMARY CARE DOCTOR _____

REFERRING PHYSICIAN _____

DATE OF BIRTH / / SEX: FEMALE MALE SOCIAL SECURITY # _____

MARITAL STATUS: SINGLE DIVORCED LEGALLY SEPERATED PARTNER
 MARRIED (SPOUSE NAME _____) WIDOWED UNKNOWN

EMPLOYER NAME _____ ADDRESS _____

EMPLOYMENT STATUS: FULL TIME NOT EMPLOYED RETIRED
 PART TIME SELF EMPLOYED ACTIVE MILITARY

STUDENT STATUS: FULL TIME PART TIME NOT A STUDENT
 SELF GUARANTOR RELATIONSHIP _____

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ DOB / /

EMERGENCY CONTACT:

NAME: LAST _____ FIRST _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EXT _____

PERMISSION TO LEAVE MESSAGE: HOME: YES NO WORK: YES NO

AUTHORIZATION TO RELEASE INFORMATION TO: NAME _____
RELATIONSHIP _____ PHONE _____

PHARMACY: NAME _____ LOCATION _____
PHONE _____ FAX _____

PRIMARY INSURANCE _____ POLICY HOLDER NAME _____

POLICY HOLDER SEX: FEMALE MALE POLICY HOLDER DOB / /

POLICY HOLDER SS#: - - POLICY HOLDER RELATIONSHIP TO PATIENT _____

ID# _____ GROUP # _____

SECONDARY INSURANCE _____ POLICY HOLDER AME _____

POLICY HOLDER SEX: FEMALE MALE POLICY HOLDER DOB / /

POLICY HOLDER SS#: - - POLICY HOLDER RELATIONSHIP TO PATIENT _____

ID# _____ GROUP # _____

PATIENT SIGNATURE _____

IF MINOR, PARENT SIGNATURE _____

**Women's Care of West Georgia, LLC
Veranet HealthCare, LLC
403 Permian Way, Suite A
Villa Rica, GA 30180
770-771-5235 / 770-771-5230
Fax 770-456-2800**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Social Security #: _____

**RELEASE TO: Women's Care of West Georgia, LLC Eric R. Vera, MD
Veranet Health Care, LLC/ M. Michelle Vera, MD
P.O Box 1615 / 403 Permian Way, Suite A
Villa Rica, GA 30180 Fax 770-456-2800**

PERMISSION IS GIVEN TO BOTH WOMEN'S CARE OF WEST GEORGIA, LLC (ERIC R. VERA, MD) AND VERANET HEALTHCARE, LLC (MERNA MICHELLE VERA, MD) TO RECEIVE AND/OR REVIEW MY MEDICAL RECORDS AS NEEDED TO PROVIDE CARE.

You are hereby authorized to release medical records from:

I, _____ hereby authorize the above name facility/physician to release my medical records including psychiatric, alcohol or drug abuse information contained. Specifically the following records:

- | | |
|---|--|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Diagnostic Reports i.e. EKG, X-Ray | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> History & Physical Notes | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> ACOG Forms | <input type="checkbox"/> Other |

The information is needed for the following purposes:

- Continued care by the receiving facility/physician
- Claims settlement with insurance company
- Needed to receive aid by the above named agency
- Legal proceedings or advice
- Personal Use
- Other

This authorization is good for a period of 90 days from the original date signed.

Patient Signature

Date

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Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of Women's Care of West Georgia, LLC and/or Veranet HealthCare, LLC Notice of Privacy Practices.

Print Name: _____.

Signature: _____.

Date: _____.

For office use only

On _____ at _____ we made a good faith attempt to obtain a written acknowledgement of receipt of our NPP, but acknowledgement could not be obtained because of the following reason:

- Patient refused to sign
- Communications barriers prevented obtaining a receipt
- An emergency prevented obtaining a receipt
- Other: _____

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FINANCIAL POLICY

Patient Name: _____ Chart/Account #: _____ (Please Print)

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a \$25 returned check charge being added to your account.
2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate on your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral it is your responsibility to obtain this prior to being seen by the doctor. If we are required to obtain the referral for you, please notify our office 72 hours prior to the specialist visit so that we have ample time to acquire this information from you insurance company.
5. **All co-payments are due at the time of service.** A \$25.00 service fee will be charged for failure to pay the co-payment at the time of service.
6. It is your responsibility to call our office 24 hours in advance to cancel your appointment. If you miss your appointment without notifying our office, you may be charged a NO-SHOW fee of \$25 for each appointment missed.
7. We charge \$25.00 per form excluding the proof of pregnancy form, sports physical and physical forms.
8. After missing three appointments without notifying us (No-Show), we can discharge you from our medical practice.

Patient Signature

Date

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Patient Name: _____ **Date:** _____

To Whom it may concern:

I give permission to the following people to receive my medical information requested:

I give permission to Women's Care of West Georgia, LLC and / or Veranet HealthCare, LLC to leave a message on my answering machine or voice mail.

Patient Name: _____

DOB: _____ **SS#:** _____

Patient or Guardian Signature

Witness

Medical History

Name: _____
Referring M.D.: _____
Main Complaint: _____

Date: _____
Other M.D.'s: _____

Other Treatment for same complaint? _____

DRUGS AND MEDICATION:

List all medications you take, including dosage.

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____

SURGERIES:

List all previous operations and approximate dates:

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____

Do you have any medication allergies? No Yes

List any other hospitalizations with reason and approximate dates:

- 1.) _____
- 2.) _____
- 3.) _____

Any anesthesia complications? No Yes

Any bleeding problems? No Yes

Have you ever had a blood transfusion? No Yes

HAVE YOU EVER HAD: (No or Yes)

- Irregular heart beat..... No Yes _____
- Angina..... No Yes _____
- Heart attack..... No Yes _____
- Congestive heart failure..... No Yes _____
- High blood pressure..... No Yes _____
- Pneumonia or lung infection..... No Yes _____
- Emphysema..... No Yes _____
- Asthma..... No Yes _____
- Jaundice..... No Yes _____
- Liver or gallbladder disease..... No Yes _____
- Ulcers..... No Yes _____
- Colitis..... No Yes _____
- Diverticulitis..... No Yes _____
- Hemorrhoids..... No Yes _____
- Other bowel disease..... No Yes _____
- Kidney disease or stones..... No Yes _____
- Bladder or kidney infection..... No Yes _____
- Prostate problem..... No Yes _____
- Stroke..... No Yes _____
- Phlebitis or blood clots..... No Yes _____
- Varicose veins..... No Yes _____
- Anemia..... No Yes _____
- Cancer..... No Yes _____
- Nervous breakdown..... No Yes _____
- Seizures..... No Yes _____
- Arthritis..... No Yes _____
- Diabetes..... No Yes _____

Other: _____

FOR DOCTORS USE

EAR, EYE, NOSE & THROAT:

- Any eye disease, injury, impaired sight?..... No Yes _____
- Any ear disease, injury, impaired hearing?..... No Yes _____
- Any trouble with nose, sinuses, mouth and/or throat?.. No Yes _____

NECK:

- Enlarged thyroid or goiter?..... No Yes _____
- Enlarged gland?..... No Yes _____

CARDIO-RESPIRATORY:

- Chronic or frequent cough?..... No Yes _____
- Chest pain, pressure, or discomfort?..... No Yes _____
- Swelling of feet or ankles?..... No Yes _____
- Shortness of breath?..... No Yes _____
- Palpitation or irregular heartbeat?..... No Yes _____
- Elevated cholesterol?..... No Yes _____

GASTROINTESTINAL:

- Double swallowing?..... No Yes _____
- Indigestion or heartburn?..... No Yes _____
- Nausea or vomiting?..... No Yes _____
- Black or bloody stools?..... No Yes _____
- Constipation or diarrhea?..... No Yes _____
- Rectal pain, swelling or bleeding?..... No Yes _____
- Abdominal pain or swelling?..... No Yes _____
- Has there been any recent change in:
 - Your appetite or eating habits?..... No Yes _____
 - Your bowel habits or stools?..... No Yes _____

GENITO-URINARY:

- Urinary frequency or burning?..... No Yes _____
- Do you get up at night to urinate?..... No Yes _____
- How many times? _____
- Any difficulty in urinating?..... No Yes _____

EXTREMITIES:

- Pain in leg or calf when walking?..... No Yes _____
- Pain or joint swelling?..... No Yes _____
- Swelling in feet or legs?..... No Yes _____
- Pain in legs at night?..... No Yes _____
- Numbness in arms or legs?..... No Yes _____
- Ulcers on hands, feet or legs?..... No Yes _____
- Weakness in legs or arms?..... No Yes _____
- Burning in legs or feet?..... No Yes _____
- Coldness in hands or feet?..... No Yes _____

NEUROLOGICAL:

- Temporary loss of vision?..... No Yes _____
- Temporary numbness or weakness of face, arm or leg? No Yes _____
- Trouble with speech?..... No Yes _____
- Fainting or loss of consciousness?..... No Yes _____
- Any recent development of headaches?..... No Yes _____
- Dizziness or vertigo?..... No Yes _____

FAMILY HISTORY:

Has any blood relative ever had: WHO?

Cancer.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Diabetes.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bleeding disorder.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Vascular problems.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart disease.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Lung problems.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Do you smoke?..... No Yes
If yes, how much? _____day
How long? _____years
Any tobacco use?..... No Yes

Do you drink?..... No Yes
If yes, how much? _____
How often? _____