Tyrone Family Medicine

Welcome to Tyrone Family Medicine. To better serve you, we ask that you complete the following forms in their entirety. Your information will be only be shared as medically necessary and detail by HIPAA regulations. If you need assistance please ask.

Thank you for choosing Tyrone Family Medicine.

Patient Demographics

Date_____

Last Name_____ First Name_____ Female Male

Address_____ City _____ State _____ Zip _____

Cell #_____ Home # _____ Work # _____

Date of Birth_____ Martial Status *Married Divorced Single* Employed: *Full Part Student Other*

Social Security # _____ Employer _____

Email_____ Ethnicity *Hispanic African American Caucasian Asian Indian Pacific Islander Other*

Emergency Contact

Emergency Contact Name_____ Relationship_____

Phone # _____ Alternate # _____

Insurance Information

- Note this information will be regarding the subscriber (person who carries policy)

☐ SAME AS PATIENT If not same as patient – Relationship_____

Last Name_____ First Name_____

Date of Birth_____ Social Security # _____

Address_____ City _____ State _____ Zip _____

Cell #_____ Home # _____ Work # _____

Employer: _____

TYRONE FAMILY MEDICINE **HISTORY & PHYSICAL** Chart #

NAME | MARITAL STATUS S M W D SEP | DATE OF BIRTH | DATE

ADDRESS | PHONE (H) (O)

OCCUPATION/ EMPLOYER | INSURANCE #

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) ALCOHOLISM
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) CANCER
3) MENTAL ILL	8) ASTHMA	13) HEART DISEASE	18)
4) GLAUCOMA	9) ANEMIA	14) STROKE	19)
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

			ALLERGIES

VACCINE YEAR OF LAST	TEST/EXAM YEAR OF LAST
TETANUS/Td	RECTAL/STOOL
FLU	CHOLESTEROL
PNEUMONIA	EYE
HEPATITIS	
TUBERCULOS	

MEDICAL HISTORY *Mark (C) for current problems. Check (✓) and indicate age when you had any of the following symptoms or diseases.*

MAIN PROBLEMS 1)_____ 2)_____ 3)_____

☐ Decreased Hearing
☐ Ringing in Ear
☐ Ear Infections - *frequent*
☐ Dizzy Spells
☐ Failing Vision ☐ Eye Pain
☐ Double or Blurred Vision
☐ Eye Infections - *frequent*
☐ Nose Bleeds - *recurrent*
☐ Sinus Trouble
☐ Sore Throat - *frequent*
☐ Hayfever / Allergies
☐ Hoarseness - *prolonged*
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic Cough
☐ Asthma / Wheezing
Shortness of Breath:
☐ on Exertion ☐ Lying Flat
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Irregular Pulse ☐ Palpitations
☐ Swollen Ankles
☐ Fainting Spells
☐ Leg Pain - *walking*
☐ Varicose Veins - Phlebitis

☐ Loss of Appetite - *recent*
☐ Difficulty Swallowing
☐ Indigestion or Heartburn
☐ Persistent Nausea / Vomiting
☐ Peptic Ulcers
☐ Abdominal Pain - *chronic*
☐ Gall Bladder Trouble
☐ Jaundice / Hepatitis
☐ Change in Bowel Habits
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Chron's / Colitis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Hernia
☐ Urine Infections - *frequent*
☐ Blood in Urine
Urination - ☐ Overnight > than twice
☐ Painful ☐ Loss of Control
☐ Decrease in Force / Flow
☐ Kidney Stones
☐ Venereal Disease
☐ Urethral Discharge
☐ Chronic Fatigue
☐ Weight Loss - *recent*
☐ Anemia ☐ Bruise Easily

☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Convulsions / Seizures
☐ Stroke
☐ Tremor / Hands Shaking
☐ Muscle Weakness
☐ Numbness / Tingling Sensations
☐ Headaches - *frequent*
☐ Arthritis / Rheumatism
☐ Back Pain - *recurrent*
☐ Bone Fracture / Joint Injury
☐ Gout ☐ Osteoporosis
☐ Foot Pain ☐ Cold Numb Feet
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping - *difficulty*
☐ Nervousness ☐ Depression
☐ Memory Loss
☐ Moodiness - *excessive*
☐ Phobias
☐ Mental Illness
_____
_____
_____

☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Measles ☐ German Measles
☐ Rheumatic Fever ☐ Scarlet Fever
☐ Tuberculosis ☐ Herpes
☐ Contact with Blood or Body Fluids

☐ Alcohol _____ oz. per week
☐ Smoking ____ cig. per day ____ yrs.
☐ Coffee / Tea _____ cups per day

FEMALES - *Please complete*
Menstrual Flow:
☐ Reg. ☐ Irreg. ☐ Pain / Cramps
____ Days of flow ____ Length of cycle
Date - First day of last period _____
☐ Pain / Bleeding during or after sex
Number of:
_____ Pregnancies _____ Abortions
_____ Miscarriages _____ Live Births
Birth Control Method _____
B.C. Pill (name) _____
☐ Flushing / Menopause
Date of last PAP Test _____
☐ Normal ☐ Abnormal
Date of last Mammogram _____
☐ Normal ☐ Abnormal

SYNOPSIS

Tyrone Family Medicine

Patient Name (Print) _____ **D.O.B.** _____

HIPAA Notice of Privacy and Security Practices: You have the right to read our Notice of Privacy and Security Practices prior to signing this Consent. A copy of the notice is available to you upon request. If you have questions or concerns, you may contact our Privacy and Security Officer, at 770-486-1200.

***May we send text or email appointment reminders? Yes _____ No _____**

We reserve the right to contact you regarding your health information. Please complete the following and initial your *preferred* means of communication:

a. ____ **You may contact me at my home telephone number:** _____
b. ____ **You may contact me by voice or text on my cell phone number:** _____
c. ____ **You may contact me at my work telephone number:** _____
d. ____ **You my send me an unencrypted email at:** _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI):
(spouse, family member, etc.)

Name_____ **Relationship** _____ **Phone**_____

Name_____ **Relationship** _____ **Phone**_____

Signature:_____ **Date:** _____

Cancellation/No Show Policy

Tyrone Family Medicine **does NOT double book; your appointment time is reserved** especially for you. We can not stress enough how important it is that you come on time and keep your appointment. We understand that there are times you may miss an appointment due to emergencies. Please call to cancel your appointment at least 24 hours prior to your scheduled time. This allows us to offer that time to another patient. If you forget or fail to show for your appointment, there will be a **$50.00 fee** charged to your account. The same applies to appointments cancelled with less than **24 hours notice**. If you accumulate three No shows in the course of one year, you may be dismissed from the practice.

Tardiness/Late for Appointment

We understand that delays can happen however we must try to keep the other patients and providers on schedule. When you are late for your appointment, we may ask you to reschedule. We do make every attempt to stay on schedule and will not delay those who are on time.

Thank you for your cooperation and understanding.

_____ _____ _____

Print Sign Date

Tyrone Family Medicine

CONSENT FOR MEDICAL TREATMENT: I hereby consent to any necessary medical diagnosis and treatment for myself, my child, or minor for whom I am legally responsible as deemed advisable or necessary by the staff of Tyrone Family Medicine.

Patient Date

Responsible Person Relationship to Patient

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any and all information contained in the named patient's medical record to the insurance company, for utilization review, claims processing, or quality assurance. I hereby authorize any hospital and/or physician to disclose and release to Tyrone Family Medicine any and all information that may have been obtained in connection with my medical treatment with the understanding that any information obtained will be treated as confidential. I also hereby authorize Tyrone Family Medicine to release any medical information necessary to another physician or hospital to which I am referred for my continued medical care.

Patient or Responsible Person Date

Relationship to Patient

ASSIGNMENT OF BENEFITS AND RIGHT OF RECOVERY: I hereby assign and authorize payment directly to Tyrone Family Medicine for any treatment or examination rendered. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

Date Patient or Responsible Person

Relationship to Patient

Date Witness

Tyrone Family Medicine

William C. Lambert, M.D. 110 Lloyd Avenue Tyrone, GA 30290 (770) 486-1200

Welcome to Tyrone Family Medicine. We thank you for choosing us for your healthcare needs.

We would like to request your records from your most recent previous primary care physician to complete our knowledge of your medical history. Therefore, we ask that you complete the following in assisting us with obtaining this information.

PATIENT NAME: _____ SS# (last 4 digits) _____

DATE OF BIRTH: _____ PHONE NUMBER: _____

PCP NAME (which we are requesting your records from): _____

PCP ADDRESS/PHONE #/or FAX #: _____

I hereby authorize TYRONE FAMILY MEDICINE – WILLIAM C. LAMBERT, M.D. to receive medical records and/or information obtained in the course of my diagnosis and/or treatment.

I hereby release TYRONE FAMILY MEDICINE – WILLIAM C. LAMBERT, M.D., from any liability which may result from this release of information. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in ninety (90) days from the date signed.

I consent to the transfer of medical, surgical, psychiatric, substance abuse, and HIV/AIDS information.

PATIENT/GUARDIAN SIGNATURE: _____ Date: _____

Witness/Tyrone Family Medicine Staff : _____ Date: _____