



## Welcome!

Thank you for choosing Marietta Family Medicine for your primary care. Below you will find our informational packet for new patients. Please take time to review and complete the following information. Should you have any questions or concerns, feel free to ask the front desk.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: Male      Female	Race/Ethnicity:
Address:		
City:	State:	Zip Code:
Cell:	Home:	Work:
Email (Needed for Portal):	Social Security:	Preferred Contact Number:
Employed: YES      NO Profession:	Marital Status:	# of Children:
Preferred Pharmacy: Name: Location:		Emergency Contact- Name: Phone:

## Insurance Information:

▪ **PRIMARY** Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Number (If Applicable): \_\_\_\_\_

▪ **SECONDARY** Insurance Company Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Number (If Applicable) \_\_\_\_\_

## Responsible Party/Guarantor Information:

Relationship to you: \_\_\_\_\_ *If "SELF," you may skip the rest of this section.*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_



**Please fill out the following information so that we understand your current medical status:**

**Current Medications: Names and Dosages**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Drug Allergies: Please list the medication and the reaction to it.**


**Medical Problems: Have you had (or do you have now) any of the following medical problems:**

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma/ cataract
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> ADHD	<input type="checkbox"/> Dementia/ Memory loss
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> Seizure/Disorder
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke/ TIA	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Positive HIV/AIDS
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Hepatitis-B/C	<input type="checkbox"/> Gout	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> DVT/PE	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other (Describe)

**Past Surgeries: (Type and Year):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Family History: Do you have a family history of:**

- High blood pressure  Yes  No If yes, what relation? \_\_\_\_\_
- Heart Disease:  Yes  No If yes, what relation? \_\_\_\_\_
- Diabetes:  Yes  No If yes, what relation? \_\_\_\_\_
- Cancer:  Yes  No If yes, what relation? \_\_\_\_\_ What type? \_\_\_\_\_
- Mental Disease:  Yes  No If yes, what relation? \_\_\_\_\_

**Social History:**

Do you smoke now  Yes  No Did you quit & when? \_\_\_\_\_

Do you use alcohol or drugs  Yes  No If yes, how many drinks/weeks? \_\_\_\_\_



## **Policies and Procedures**

### **Scheduling:**

Patients can request appointments through the patient portal available via the HEALOW App or online at <http://mariettafamilymed.com>. Alternatively, appointments can be scheduled by phone at (678) 741-7185, by text at (844) 252-3330, or by office.

It is the Responsibility of the Patient/Guardian to give office staff any updated information changes including, but not limited to, Insurance, Pharmacy Information, Address, Phone Number, etc. Personal information may also be updated via the Patient Portal. Insurance card(s) should be brought to every visit. Insurance updates for primary care providers may need to be filed with insurance prior to appointments. Marietta Family Medicine CANNOT be held responsible for any fees incurred by a patient failing to give updated information.

We ask that all patients arrive 15 minutes before their scheduled time.

### **Payment:**

Co-Payments will be requested at the time of visit for all services which are non-covered by insurance or which are determined to be the patient's responsibility, including copayments and deductibles, Prior Authorizations for insurance and legal forms including but not limited to Disability and FMLA paperwork. Patients WILL be billed for remaining balances not covered by their insurance. Accepted forms of payment are Visa, Master Card, Discover, or Cash.

### **Medication Refills:**

Medications will NOT be refilled without required follow up visits. Depending on medical necessity, you may be required to follow up every 1-6 months as determined by your physician. It is the patient's responsibility to make follow up appointments prior to need of refills, and it is recommended that you make your follow-up appointment upon completing your current visit. If for any reason a refill is needed between follow-up visits, you should allow 48 hours for your pharmacy to receive your request. There are no exceptions to this policy. Please understand that this policy is for your safety and in your best interest.

### **Cancellation Policy:**

We realize that patients may need to change their appointments; however, we require a notice 24 hours prior to your original appointment time so that we may offer that time to another patient. Failure to cancel without due notice, may result in a \$55.00 cancellation fee. This fee will not be submitted to insurance and it will be the patient's sole responsibility for payment. Please call 24 hours in advance to reschedule or cancel your appointment. We understand that circumstances beyond your control may arise and, in these cases, we ask that you inform us as soon as possible.

### **After Hours:**



Visit the patient portal via the HEALOW App or online at <http://mariettafamilymed.com> for appointment scheduling and lab/test results. Other issues will be handled during office hours.  
**May we discuss billing/medical information with another person other than yourself, if so please list:**

1: \_\_\_\_\_ phone: \_\_\_\_\_

2: \_\_\_\_\_ phone: \_\_\_\_\_

▪ **Financial Responsibility:**

I understand that it is the responsibility of each patient to arrange for payment for medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Marietta Family Medicine and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

*Patient or Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

▪ **Consent for Treatment:**

Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory tests, medications or exams as deemed necessary by the physician, physician assistant, and/or nurse practitioner.

*Patient or Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

▪ **Release for Treatment of a Minor (if applicable):**

Except under certain legal exemptions, a parent or guardian signature is required for the treatment of a minor. I am the parent/guardian for \_\_\_\_\_ and give Marietta Family Medicine authorization to provide treatment.

*Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

▪ **Policies and Procedures:**

I have been provided the opportunity to read, or it has been read to me, the "Policies and Procedures" at Marietta Family Medicine. I understand these policies and being of sound mind am signing in agreement and acknowledgement of the policies provided to me.

*Patient or Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

▪ **Consent to Obtain Medical Records:**

-I hereby authorize Marietta Family Medicine to obtain medical records from any other physician or medical facility necessary in the course and duration of any treatment.

*Patient or Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

-I hereby consent to Marietta Family Medicine obtaining my medication history from other providers/pharmacies:

*Patient or Parent/Guardian Signature:* \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**Patients Initials** \_\_\_\_\_

**Patient Health Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

**Scoring Guide:**

0                    1                    2                    3

	Not at all	Several Days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				+
9) Thoughts that you would be better off dead or of hurting yourself in some way				

**Tallying Result Count:**

Total score: \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people



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Not difficult at all	Somewhat difficult	Exceedingly difficult	Extremely difficult
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