# Premier Medical Clinic

506 Harley Street Scottsboro, AL 35768
Phone:256-259-6838 Fax:256-259-6838
Dr.M.E. Ata M.D, Dr. S. Gibson, Janna Culpepper C.R.N.P

Patient Name:_____Date Of Birth:_____

SS#_____-_____-_____Sex: M F Race:_____Marital Status: S M D W

Home Phone#_____Cell Phone#_____

Email:_____

Patient Address:_____

City:_____State:_____Zipcode:_____

Pharmacy:_____

ALLERGIES:_____

Emergency Contact Info

Name:_____Relationship to patient:_____

Name:_____Relationship to Patient:_____

INSURANCE

Primary Insurance:_____Policy/Group#_____

Card Holder Name:_____Card Holder D.O.B_____

Secondary Insurance:_____Policy/group#_____

Card Holder Name:_____Card Holder D.O.B_____

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Guarantee of Account: I Accept financial responsibility and guarantee payment to Premier Medical Clinic for all professional services and expenses related to the above names persons.This shall include any and all future services,as well as those presently contemplated.I authorize the release of any medical information necessary to process this claim in request of payments for benefits to Premier Medical Clinic.I agree to pay attorney fees/collection agency fees in the event that any debt for services/expenses is placed in collection.I agree that any controversy,including any malpractice claims related to the past,present and future care,diagnosis and treatment of the patient by Premier Medical Clinic,including partners,agents or employees of the physician shall be submitted to binding arbitration.

_____ _____

Signature of Patient/Authorized Person Date Signed

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICES

These policies describe how medical information about me may be used and disclosed.
These policies also contain information regarding how I may be able to access my medical information.
I have been made aware of the Privacy policies of the Premier Medical Clinic.
These policies are posted inside the Premier Medical Clinic and are available to me upon my request at any time.
I authorize Premier Medical Clinic and the staff of the clinic to disclose my health information.
I understand that no information will be disclosed or discussed with any persons not listed below.

| NAME | RELATIONSHIP TO PATIENT |
|---|---|
| | |
| | |
| | |

I understand that the health information used or disclosed with my authorization to Premier Medical Clinic may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

Patient Name _____ Date _____

Patient Representative _____ Date _____

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## GENERAL CONSENT TO OUTPATIENT TREATMENT

I, the patient, request and authorize Premier Medical Clinic to administer care as my physician or designee/assistants (collectively called "The physicians")deemed necessary or advisable.This care may include,but is not limited to,routine diagnostic radiology and laboratory procedures as well as the administration of routine drugs, I hereby authorize my physician to perform other additional or extended services in the event of an emergency situation.If it deems necessary or advisable in order to preserve my life and /or health. I understand that my care is directed by my physician's instructions. I hereby consent to hepatitis and H.I.V testing should my physician's or any employee of Premier Medical become exposed to my blood or any other bodily fluids. I am aware that the practice of medicine and surgery is not an exact science and I hereby acknowledge that no guarantees or promises have been made to me with the respect of such diagnostic procedures and treatments.

**Personal Valuables**

I understand that I am responsible for any and all personal valuables that I bring with me to the clinic.I hereby release Premier Medical Clinic from any and all liability for the loss,theft,or damage of any and all personal possessions of which I have chosen to keep with me during my treatments,I have read and I understand that I have the right to ask questions and to have these questions answered.

| | |
|---|---|
| Patient name(printed) | Date |
| Patient representative(printed) | Date |
| Signature | Date |

NAME:_____DATE OF BIRTH:_____

**FAMILY HISTORY(CIRCLE YES OR NO)**

| | | |
|---|---|---|
| ANEMIA | YES | NO |
| BLEEDING TENDENCY | YES | NO |
| CRIPPLING ARTHRITIS | YES | NO |
| HEART DISEASE | YES | NO |
| CHRONIC LUNG DISEASE | YES | NO |
| TUBERCULOSIS | YES | NO |
| HIGH BLOOD PRESSURE | YES | NO |
| KIDNEY DISEASE | YES | NO |
| ASTHMA | YES | NO |
| SEVERE ALLERGIES | YES | NO |
| MENTAL ILLNESS | YES | NO |
| CONVULSIONS | YES | NO |
| DIABETES | YES | NO |
| CANCER | YES | NO |

**OPERATIONS(CIRCLE YES OR NO)**

| | | |
|---|---|---|
| TONSILS | YES | NO |
| APPENDIX | YES | NO |
| GALLBLADDER | YES | NO |
| STOMACH | YES | NO |
| BREAST | YES | NO |
| UTERUS/OVARY | YES | NO |
| PROSTATE | YES | NO |
| HERNIA | YES | NO |
| THYROID | YES | NO |
| VARICOSE VEINS | YES | NO |
| HEMORRHOIDS | YES | NO |
| HEART | YES | NO |

OTHER_____
_____

**SOCIAL HISTORY**

DO YOU DRINK ALCOHOL YES NO
HOW MANY?_____
DO YOU SMOKE YES NO
HOW MANY?_____DAY____
SMOKELESS TOBACCO? YES NO
USE DRUGS? YES NO
WHAT KIND?_____
USE CAFFEINE? YES NO

**PAST MEDICAL HISTORY(CIRCLE YES OR NO) HAVE YOU EVER HAD**

| | | | | | |
|---|---|---|---|---|---|
| MEASLES | YES | NO | ULCER | YES | NO |
| MUMPS | YES | NO | CANCER | YES | NO |
| VENEREAL DISEASE | YES | NO | BLOOD TRANSFUSION | YES | NO |
| TUBERCULOSIS | YES | NO | ANGINA | YES | NO |
| EXPOSURE TO TB | YES | NO | DIABETES | YES | NO |
| BRONCHITIS | YES | NO | KIDNEY DISEASE | YES | NO |
| PNEUMONIA/PLEURISY | YES | NO | ANEMIA | YES | NO |
| HEPATITIS | YES | NO | HIGH BLOOD PRESSURE | YES | NO |
| BLADDER INFECTIONS | YES | NO | ARTHRITIS | YES | NO |
| ASTHMA | YES | NO | EMPHYSEMA | YES | NO |
| ARTHRITIS | YES | NO | HEART DISEASE | YES | NO |
| BACK PAIN | YES | NO | HAY FEVER/SINUSITIS | YES | NO |

**GENERAL(CIRCLE YES OR NO)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| TIRE EASILY | YES | NO | LOSS OF HEARING | YES | NO | CHEST PAIN | YES NO |
| WEAKNESS | YES | NO | RINGING IN EARS | YES | NO | SWELLING | YES NO |
| WEIGHT CHANGES | YES | NO | LUMPS IN BREAST | YES | NO | PALPITATIONS | YES NO |
| RASH: | YES | NO | SHORT OF BREATH | YES | NO | HEARTBURN | YES NO |
| NAUSEA | YES | NO | VOMITING | YES | NO | HEMORRHOIDS | YES NO |
| RECTAL BLEEDING | YES | NO | CONSTIPATION | YES | NO | DIARRHEA | YES NO |
| INCREASE IN FREQUENCY OF URINATION | | | | YES | NO | UNABLE TO HOLD URINE | YES NO |
| FEEL THE NEED TO URINATE W/O MUCH URINE | | | | YES | NO | DISCHARGE /BLOOD | YES NO |
| PAIN OR BURNING WHEN URINATING | | | | YES | NO | LACK IN SEX DRIVE | YES NO |
| MUSCLE CRAMPS | YES | NO | MUSCLE WEAKNESS | YES | NO | STIFFNESS | YES NO |
| PAIN/SWELLING | YES | NO | HEADACHES | YES | NO | DIZZINESS | YES NO |
| FAINTING | YES | NO | CONVULSIONS | YES | NO | DEPRESSION | YES NO |
| NERVOUSNESS | YES | NO | TROUBLE SLEEPING | YES | NO | | |

**OBGYN**

STARTED MENSTRUATING AT AGE_____DATE OF LAST PAP_____
HOW MANY DAYS BETWEEN PERIODS_____DURATION OF PERIOD_____DAYS.
PAIN WITH PERIODS YES NO NUMBER OF BIRTHS_____
NUMBER OF PREGNANCIES_____NUMBER OF MISCARRIAGES_____

## MEDICATIONS TAKEN REGULARLY

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____DOSE:_____ HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____

NAME:_____ DOSE:_____HOW OFTEN:_____