NORTHSIDE PRIMARY CARE

Dr AAZRUM I. SYED, M.D.

11820 Northfall Lane Suite 1103

Alpharetta, GA 30009

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____ have received and was asked to read this offices' Notice of Privacy Practices.

_____

Please print name

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our privacy practice but acknowledge could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: (please specify) _____
  _____
  _____

If you have any questions regarding this notice or our information, privacy policies please contact Northside Primary Care at 678-867-0904

Northside Primary Care, INC.

11820 Northfall Lane, Suite 1103

Alpharetta, GA 30009

FAMILY HISTORY FOR COMMON HEREDITARY CANCER SYNDROMES

Patient Name: _____ Date: _____

Date of Birth: _____

Instructions: Please circle yes to any that apply to you and/or your family (both mother/father sides). Please list relationship to you and if known, the age at which they were diagnosed. This is a screening for the common features of hereditary cancer. If you circle yes, to any of the following, you may be appropriate for testing of these cancers. Please ask you healthcare provider for further information.

BREAST AND OVARIAN CANCER:			**RELATIONSHIP**	**AGE DIAGNOSED**
Yes	No	Breast cancer before age of 50	_____	_____
Yes	No	Ovarian cancer	_____	_____
Yes	No	Breast cancer in one or both breasts	_____	_____
Yes	No	Both breast and ovarian cancer	_____	_____
Yes	No	Male breast cancer	_____	_____
COLON AND UTERINE CANCER:				
Yes	No	Uterine cancer before age of 50	_____	_____
Yes	No	Colorectal cancer before age of 50	_____	_____
Yes	No	Uterine and/or colorectal cancer AND ovarian Stomach, kidney/urinary tract, brain OR small Bowel cancer (individual or family)	_____	_____
Yes	No	10 or more colon polyps found in lifetime	_____	_____

Patient Signature & Date: _____

NORTHSIDE PRIMARY CARE
DR. AAZRUM I. SYED, M.D.
11820 NORTHFALL LANE SUITE 1103
Alpharetta, GA 30009
P 678-867-0904/ F 678-867-0905

MEDICAL RELEASE FORM

Patient authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize certain protected health information about me to be released.

*Records to be **released** from:*

*Records to be **sent** to:*

NORTHSIDE PRIMARY CARE, INC
DR. AAZRUM I SYED, M.D.
11820 NORTHFALL LANE S1103
ALPHARETTA GA, 30009
678 867 0905 FAX

The following information is to be released/reviewed:

History @ Physical Exam Discharge Summary Operative reports ER Reports Films

Hospital Outpatient Reports Lab Reports Pathology Reports X-Ray/Radiology Reports

Consultation Reports Clinical Notes

Other:_____

Date: _____

_____

**Patients signature: _____

**PT D.O.B. _____/_____/_____

PT Printed Name: _____

Phone Number: _____

If Legal Guardian is signing please fill in the following:

_____ _____Date: _____

Northside Primary Care, INC.

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BASIC PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ SS#: _____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Email address (only for communication with you): _____

Employer: _____ Work Phone: _____

Race: _____ Ethnicity: _____

Barriers to Communication (circle one, if any): HEARING/VISION/OTHER _____

Do you speak English? _____ If no, what language? _____

If the patient is under 18 years of age, who is the responsible party?

Last Name: _____ First Name: _____ MI: _____

Address (if different from patient): _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ SS #: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact number: _____

Primary Insurance Company: _____

Subscriber Name: _____ DOB: _____

Subscriber relationship to patient (circle one): SELF/SPOUSE/CHILD

ID #: _____ Group #: _____ Effective Date: _____

Secondary Insurance Company: _____

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Subscriber Name: _____ DOB: _____

ID#: _____ Group #: _____ Effective Date: _____

We utilize an electronic prescription service, so please provide the following information:

Preferred Pharmacy Name: _____

Address (if unknown, give city, state and intersection):

_____

Phone Number: _____

I gave Northside Primary Care, INC. permission to obtain my prescription history from the pharmacy(s) listed above to be used as part of my medical records.

Printed Name (Patient):

Patient Signature and Date:

I understand that I will be fully responsible to Northside Primary Care, INC and Dr. Aazrum Syed for any and all charges that is performed and not covered by my insurance company(s). I also understand that that charges that are covered are not always paid for by the insurance company, as deductibles, co-pays, co-insurances, percentages, pre-existing conditions determinations, etc., may be applied as amounts that I owe personally. I also understand that the staff of this practice cannot determine what amount of payment will be paid by the insurance company. I also agree that after 60 days, all outstanding amounts not paid by the insurance company will be my full responsibility. I authorize the release of any medical information needed to process the claims and to coordinate care with other physicians and/or other medical facilities that I may be referred to as a result of my treatment at Northside Primary Care, INC.

Printed Patient Name and Date:

Signature of Patient and/or parent (if minor):

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MEDICAL HISTORY QUESTIONAIRE

Patient Name_____ **Date:** _____

FAMILY HISTORY (Please indicate which family has or had any of the following):

Cancer _____ Tuberculosis _____ Thyroid_____

Arthritis_____ Diabetes_____ Epilepsy_____

Anemia _____ Cholesterol_____ Hypertension_____

Gout_____ Blood Clots_____ Mental Illness_____

Kidney Disease_____Heart Disease_____ Other_____

SURGICAL HISTORY (Please provide date/year/place of surgery if possible):

Appendectomy_____Cholecystectomy_____Sinus_____

Hip Replacement_____Hysterectomy_____Tonsillectomy_____

Hernia Repair_____Knee Replacement_____Other_____

PATIENT HISTORY (Please check beside any that you have/had any of the following):

Measles_____Arthritis_____Epilepsy_____

Mumps_____Angina_____Pneumonia_____

Asthma_____HIV_____Chicken Pox_____

Thyroid_____Hypertension_____Appendicitis_____

Cancer_____Tuberculosis_____Kidney Stones_____

Scarlet Fever_____Heart Attack_____Heart Murmur_____

Heart Disease_____Bladder Infections___Blood Clots_____

Rheumatoid_____Migraines_____Lung Disease_____

Dizziness_____Stroke_____Other_____

Phone: 678-867-0904 Fax: 678-867-0905

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Patient Name: _____ Date: _____

SOCIAL HISTORY (Please answer all questions as accurately as possible, circle the answer):

Exercise Regularly? YES/NO If yes, how often? _____

Are you a smoker? YES/NO If yes, how many cigarettes/packs per day? _____

Do you use any street drugs? YES/NO If yes, what type of drug? _____

CURRENT MEDICATIONS (Please include strength and dosage if known):

1._____

2._____

3._____

4._____

5._____

ALLERGIES: _____

PATIENTS OVER THE AGE OF 50:

Date of Last Colonoscopy? _____

PATIENTS WITH DIABETES:

Date of Last Diabetic eye exam? _____

FOR WOMEN ONLY (MENSTRUAL HISTORY):

Date of last period: _____

Date of last Pap smear: _____

# of children: _____

# of miscarriages: _____

# of Abortions: _____

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678-867-0904 phone/678-867-0905 fax

OFFICE POLICIES

APPOINTMENTS: Patients are seen by appointment, in most cases, we can arrange for same day appointments. Upon check-in, you will be asked to update your information on insurance and any demographic changes. When submitting your insurance we would like to have the most updated information. _____ (initial)

Late policy: We strive to honor appointment times and respect patient's schedules. For this reason, patients who show up late may be asked to reschedule if we are unable to work you into the schedule for that day. Please call in advance if you feel that you will not be able to make your scheduled appointment a 24-hour cancellation policy with a $25.00 fee may apply. Patients who do not call and cancel appointments and fail to show up on a recurring basis may be considered for dismissal from the practice. _____ (initial)

Rx Refills: Prescription refills are generally handled during your office visit, but if this is not possible, please contact our office. Messages received in the morning are called out by the close of the business day. Calls received in the afternoon will be returned the next business day. All patients must have been seen within 3 months to obtain refills. _____ (initial)

Referrals: Please not that it may take up to 48 hours to obtain a referral to a specialist. In most cases, referrals can be given the same day. Please discuss this with the physician at the time of your visit. ____ (initial)

Lab Results: Lab results are usually available within two days depending on the type of testing being completed. Please speak with the office to get more information as to when your test results will be in. The physician may require you to schedule an additional office visit to go over test results in some cases.

_____ (initial)

Insurance and Billing: Patients are responsible for a co-payment or deductible which we will ask you to pay at the time of your visit. Deductibles are expected in full unless special arrangements are made. We do not want issues of payment to keep you from taking care of yourself and your health; we will make arrangements through our office which can be discussed at the time of your visit. Monthly statements on past due amounts will be mailed monthly. _____ (initial)

Fees billed to your insurance company are our usual and customary rates, which are competitive with physicians of the same specialty in our area. Insurance carriers, however, have their own methods of determining standard "allowable" charges which at times are lower. Patients are responsible for paying the difference between their insurance carrier's allowable charges and our fees. We accept cash, check*, credit and debit cards including MasterCard/Visa/Discover/American Express.

*There is a $30 charge on all returned checks. _____ (initial)

Medical Records: Request for your medical records from our office requires your signature on the Medical Release form. Medical records are available with adequate notice. If you would like to request a copy of your records please complete the form while at our office or request the form to be faxed or emailed to you. There will be a charge depending on how many pages please call for rates. Charges for copying are in accordance with State provisions. There is no charge if your records are to be copied and sent to a physician or medical facility. _____ (initial)

By initialing/signing I agree to the above terms.

_____

Patient Signature

_____

Patient Name Print

_____

Date

_____

DOB

NORTHSIDE PRIMARY CARE

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Patient Consent Form

Print Name: _____Date:_____

SS#: _____D.O.B: _____

Please Note: As our patients we want you to know that we respect the privacy of your personal medical records and will do all we can to protect your privacy. You may refuse to consent to the use or disclosure of you personal health information, but this must be in writing. We have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information.

I understand that as a part of my healthcare, Northside Primary Care maintains personal health information describing my health history, symptoms, exam, and test results, diagnosis, treatment and any for future care or treatment.

I understand that this information serves as:

1. A basis of planning and treatment.
2. A means of communications among the healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and treatment information to my bill.
4. A means by which a third party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

1. To object to the use of my health information for directory purposes.
2. To request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations-and that Northside Primary Care is not required to agree with restrictions requested.
3. To revoke this consent in writing, except to the extent that Northside Primary Care has already taken action in reliance thereon.

I request the following restriction to the use or disclosure of my health information

_____

_____

Patient: _____ _____ _____

Signature of Patient/Legal Rep. Date Witness Signature

For Office Use: Accepted Denied

_____ _____

Signature Date

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PATIENT IMMUNIZATION RECORD

Patient Name: _____ Date of Birth: _____

Today's Date: _____

Immunization History	If yes, please give month and/or year given	
Tetanus (primary series then booster every 10 years)	YES/NO	DATE: _____
MMR (Rubella screen child bearing age female)	YES/NO	DATE: _____
Hepatitis A (series of 2 completed)	YES/NO	DATE: _____
Hepatitis B (series of 3 completed)	YES/NO	DATE: _____
Pneumonia (especially age 65 and over or with chronic illness)	YES/NO	DATE: _____
Flu Vaccine (annually)	YES/NO	DATE: _____
Shingles Vaccine	YES/NO	DATE: _____
Meningitis (especially college bound)	YES/NO	DATE: _____
PPD (if negative, yearly skin test)	YES/NO	DATE: _____

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