UNION GENERAL AFFILIATED SERVICES

Patient Data
FORM MUST BE COMPLETED IN FULL

Patient Name____ **Todays Date**__________________

Date of Birth__________________ **Social Security #** ______/_____/_______ **Gender** ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Mailing Address ____
Street City State Zip

Phone Numbers Home_________________ Cell____________________ Work__________________

Primary Phone is ☐ Home ☐ Cell ☐ Work **Reminder Call Made to** ☐ Home ☐ Cell ☐ Work

May we leave a personal message on your answering machine regarding any or all ongoing medical conditions? ☐ Yes ☐ No

Do we have permission to talk to another person(spouse,family member, friend) about your medical condition? ☐ Yes ☐ No

List Names____

Email Address:____ ***(This will allow you to access our patient portal)***

Preferred Contact Method ☐ Phone ☐ Mail ☐ Email
Preferred Language ☐ English ☐ Spanish ☐Unknown ☐ Other___________________
Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ White ☐ Other Race ☐ Unknown ☐ Declined
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Primary Physician____

Guarantor Name: *(if patient is a minor)*: __________________________ **Relation to Patient:** _____________
Guarantor Address: ____
Guarantor Date of Birth: ______________________ **Guarantor Phone Number:** (____)_____________

Employer________________________________ Address_______________________________________
☐ Retired, effective month/date______________________ ☐ Student ☐ Unemployed

Emergency Contact
Spouse, companion, relative or friend living with you
Name & Date of Birth__________________________________ Relationship to you______________________
Phone Number______________________________

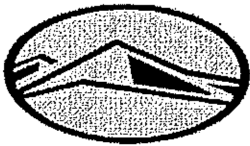
Insurance Information
Primary________________________ Policy # _______________________Group #__________
Name of Insured & their relationship to you ____________________________DOB____________

Secondary _______________________Policy# _______________________Group #__________
Name of Insured & their relationship to you ____________________________DOB____________

Preferred Pharmacy ________________________ Pharmacy Phone_______________________
City/State____
I authorize Union General Affiliated Services to obtain my prescription history electronically. ☐ **Yes** ☐ **No**

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY*(If patient is a minor, must be signed by parent/legal guardian)*
I certify that the above information is correct. I consent to be treated by the staff and providers of Union General Affiliated Services. I authorize payment of medical benefits to Union General Affiliated Services and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient/Guarantor Signature____Date____________________



UNION GENERAL HOSPITAL
YOUNG HARRIS CLINIC

AFFILIATE OF: UNION GENERAL HOSPITAL INC.

PLEASE SIGN AND DATE EACH ITEM BELOW

ACKNOWLEDGEMENT AND AUTHORIZATION:

• I have read and understand the HIPAA/Privacy policy for CHATUGE REGIONAL HOSPITAL INC DBA UNION GENERAL CLINIC AT YOUNG HARRIS

Signed:______________________________________ Date:_______________________

• I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed:______________________________________ Date:_______________________

• I authorize CHATUGE REGIONAL HOSPITAL INC DBA UNION GENERAL CLIMIC AT YOUNG HARRIS to release medical information required to process my claim

Signed:______________________________________ Date:_______________________

• I have read and understand the Financial Polict for CHATUGE REGIONAL HOSPITAL INC DBA UNION GENERAL CLINIC AT YOUNG HARRIS

Signed:______________________________________ Date:_______________________

• I authorize my provider's office to contact me by my mobile phone

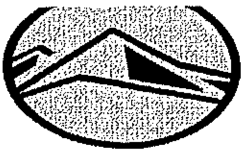
Signed:______________________________________ Date:_______________________

• I authorize Union General Hospital Young Harris Clinic to release and disscuss any of my protected health information such as appointments date and times, diagnosis and treatment plans, test results and medication information to the following people.

Name:____________________ Relationship:________________ Number:________________
Name:____________________ Relationship:________________ Number:________________

I understand this authorization remains in effect until I revoke it in writing

Signed:______________________________________ Date:_______________________



UNION GENERAL HOSPITAL YOUNG HARRIS CLINIC

AFFILIATE OF: UNION GENERAL HOSPITAL INC.

First, Middle, Last Name: ______________________ **Date of Birth** ____________

List any Medication Allergies:

Name of Drug: ______________________
Name of Drug: ______________________
Name of Drug: ______________________
Name of Drug: ______________________

List Current Medications:

Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________
Name of Drug/Dose/Frequency: ______________________

Vaccines/Injections:

Vaccine			
Hepatitis A	(NO)	(YES)	Date: ____________
Hepatitis B	(NO)	(YES)	Date: ____________
DTAP/Td	(NO)	(YES)	Date: ____________
MMR	(NO)	(YES)	Date: ____________
Flu	(NO)	(YES)	Date: ____________
Shingles	(NO)	(YES)	Date: ____________
Pneumonia 13	(NO)	(YES)	Date: ____________
Pneumovax 23	(NO)	(YES)	Date: ____________
Tetanus	(NO)	(YES)	Date: ____________
Varicella Vaccine	(NO)	(YES)	Date: ____________

Family History

Mark all that apply to mother, father, sidings

Heart Disease Describe: ______________________
Stroke Describe: ______________________
Diabetes Describe: ______________________
Cancer Describe: ______________________
Lung Disease/Breathing Problems Describe: ______________________
Liver Disease Describe: ______________________
Kidney or Bladder Disease Describe: ______________________
Mental Issues/Illness Describe: ______________________
Other Describe: ______________________

Social History

Marital Status (Circle one)	(Single)	(Married)	(Divorced)	(Other)
Do you work? (YES) (NO)	Current Employer?		________________	
What is level of education completed?	High School	College	Other: ________	
Do you exercise?	(NO)	(YES)	How often? ________	
What are your hobbies?	________________			
Describe Current Level of Stress:	________________			
Do you live alone?	(NO)	(YES)		
Smoking Status (Circle One)	Current Smoker	Never Smoked	Former Smoker	________
Chewing tobacco (Circle One)	Current Use	Never Used	Former User	________
Do you drink Alcohol?	(NO)	(YES)	How many?	How Often? ________
Have you ever used Illicit Drugs	(NO)	(YES)	For how long? ________	
Have you ever used IV drugs?	(NO)	(YES)	For how long? ________	
Do you have any current Vision problems?	(NO)	(YES)	Describe: ________	
Do you have any difficulty hearing?	(NO)	(YES)	Describe: ________	
Do you have an Advanced Directive?	(NO)	(YES)		

Surgical History

List Any Surgeries

1 ________________________________ Date: ____________
2 ________________________________ Date: ____________
3 ________________________________ Date: ____________
4 ________________________________ Date: ____________
5 ________________________________ Date: ____________
6 ________________________________ Date: ____________

Past Medical History

Heart Disease	(NO)	(YES)	Describe: ________
Stroke	(NO)	(YES)	Describe: ________
High Cholesterol	(NO)	(YES)	Describe: ________
High Blood Pressure	(NO)	(YES)	Describe: ________
Diabetes	(NO)	(YES)	Describe: ________
Cancer	(NO)	(YES)	Describe: ________
Ear or Hearing Problems	(NO)	(YES)	Describe: ________
Vision or Eye Problems	(NO)	(YES)	Describe: ________
Sleep Apnea	(NO)	(YES)	Describe: ________
Lung Disease/Breathing Problems	(NO)	(YES)	Describe: ________
GI Problems	(NO)	(YES)	Describe: ________
Liver Disease	(NO)	(YES)	Describe: ________
Kidney or Bladder Disease	(NO)	(YES)	Describe: ________
Headaches	(NO)	(YES)	Describe: ________
Skin Diseases/Problems	(NO)	(YES)	Describe: ________
Muscle/Joint/Bone Problems	(NO)	(YES)	Describe: ________
Arthritis	(NO)	(YES)	Describe: ________
Thyroid Problems	(NO)	(YES)	Describe: ________
Blood Diseases	(NO)	(YES)	Describe: ________
Mental Issues/Illness	(NO)	(YES)	Describe: ________
Breast Problems	(NO)	(YES)	Describe: ________
Circulation Problems	(NO)	(YES)	Describe: ________

Quality Measures

	Date		
Annual Wellness/Physical	______	Results:	______
Mammogram (*female*)	______	Results:	______
PAP (*female*)	______	Results:	______
Osteoprosis Screening(*female*)	______	Results:	______
PSA (*male*)	______	Results:	______
Colon Cancer Screening	______	Results:	______
Lung Screening	______	Results:	______
Hep C Screen (born 1945-1965)	______	Results:	______
EKG	______	Results:	______
Other	______		

Review of Systems

Constitutional			**GU**		
Weight Loss	(YES)	(NO)	difficulty urinating	(YES)	(NO)
Weight Gain	(YES)	(NO)	loss of control/leaking	(YES)	(NO)
fatigue	(YES)	(NO)	increased frequency	(YES)	(NO)
trouble sleeping	(YES)	(NO)	inability yo empty bladder	(YES)	(NO)
Eyes			**Musculoskeletal**		
Change on vision	(YES)	(NO)	back pain	(YES)	(NO)
ENT			joint pain	(YES)	(NO)
Nosebleeds	(YES)	(NO)	trouble walking	(YES)	(NO)
sinus problems	(YES)	(NO)	neck pain	(YES)	(NO)
sore throat	(YES)	(NO)	limited range of motion	(YES)	(NO)
bleeding/sore gums	(YES)	(NO)	**SKIN**		
dry mouth	(YES)	(NO)	rashes	(YES)	(NO)
snoring	(YES)	(NO)	growths/lesions	(YES)	(NO)
Cardiovascular			trouble healing	(YES)	(NO)
chest pain	(YES)	(NO)	change in color	(YES)	(NO)
arrythmia/palpitations	(YES)	(NO)	**NEURO**		
ankle swelling	(YES)	(NO)	frequent/severe headaches	(YES)	(NO)
Respiratory			weakness	(YES)	(NO)
Shortness of Breath	(YES)	(NO)	dizziness	(YES)	(NO)
coughing	(YES)	(NO)	numbness	(YES)	(NO)
wheezing	(YES)	(NO)	**PSYCH**		
GI	(YES)	(NO)	depression	(YES)	(NO)
abdominal pain	(YES)	(NO)	anxiety	(YES)	(NO)
nausea	(YES)	(NO)	memory loss	(YES)	(NO)
vomiting	(YES)	(NO)	**ENDROCRINE**		
black tarry stools	(YES)	(NO)	Heat or Cold Intolorance	(YES)	(NO)
diarrhea	(YES)	(NO)	Excessive thirst	(YES)	(NO)
reflux/heartburn	(YES)	(NO)	**HEMATOLOGICAL/LYMPH**		
			Abnormal bleeding	(YES)	(NO)
			Bruise easily	(YES)	(NO)

____

Patient Signature *Date*

____

Provider Signature *Date*

Patient Name______________________________ DOB____________________

UNION GENERAL YOUNG HARRIS CLINIC
LABORATORY SELECTION FORM

My provider has ordered a lab test for me, and collected the specimen(s) in his/her office.

( ) I want collection of the specimen in office and testing to be done at Union General Hospital.

( ) I want collection of the specimen in the office and sent to LabCorp.

( ) I want collection of the specimen in the office and sent to Quest.

( ) Unsure. Please call the 1-800 number on the back of your insurance card and ask your insurance company if there is a "preferred lab".

X____ ____________________
Patient (or Patient Representative) Date

Note: Specimens cannot be sent to outside labs Saturday-Sunday, Holidays, or any day prior to a holiday. Emergency (STAT), and pre-requisite labs for procedures drawn at this facility must be done at UGH.

OFFICE USE ONLY

Registrar, if patient selects:

Option 1, set up patient's insurance or collect agreement to pay.

Option 2, draw specimen and send insurance info with card and specify on lab order to be sent to LabCorp.

Sign and date below, have scanned into patients chart and send hard copy along with lab order.

X____ ____________________
Registrar Date

HIPAA AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

TO: Union General Health Systems Clinics

Patient's Full Legal Name: ______________________________ Date of Birth: ____________________

Medical Records # ______________________________ *[To be completed by Hospital]*

Address: ____

Home Telephone: ______________________________ ❑Preferred Phone Number (Check if applies)

Cell Phone Number: ______________________________ ❑Preferred Phone Number (Check if applies)

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 164.512 and 164.508, I hereby authorize UGHS Clinics to disclose my protected health information, as described below to the following individuals: **[Insert Name and Contact Number in Table Below]**

Name	**Contact Number**

I authorize UGHS Clinics to disclose to the individuals above any information related to my medical information, including all information contained in the medical records at UGHS Clinics and any test results, billing information, account information, appointment information and any other clinical information about my healthcare services and how I pay for the healthcare services. The purpose of this Authorization is to ensure communication to myself and individuals that I designate to receive my healthcare information.

I further authorize the UGHS Clinics to leave phone messages on the number below to communicate with me about appointments, test results and personal health information contained in my medical records. I understand that I am responsible for the content and security of any phone messages left on the number below.

❑Home Number listed above
❑Patient Cell Phone Number listed above
❑ ______________________________ [Enter Other Phone Number Where Messages May be Left]

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), HUMAN IMMUNODEFICIENCY VIRUS (HIV), BEHAVIORAL OR MENTAL HEALTH SERVICES, AND/OR TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE. I AUTHORIZE THE RELEASE OF SUCH INFORMATION, WITH THE FOLLOWING EXCEPTIONS:

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. I understand that I am waiving my right to privacy and this information may be disclosed by the recipient. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the Hospital's Privacy Officer at *maggiecampbell@uniongeneral.org*. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits. I understand that I may request a copy of this Authorization form, after signing it.

This authorization will expire after twenty four (24) months (two years).

______________________________ ______________________________
Patients Name (Printed) ***Legal Guardian's Name (Printed if applicable)***

______________________________ ______________________________
Signature of Patient (over 18 years of age) or Legal Guardian ***Date***

Form # 600005 **Revised: 10/2018**

PATIENT STICKER