Kennestone Family Medicine

Building a Healthy Community One Individual at a time

Sam Peng, MD

Name: Last	First:	Middle (initial):
Date of Birth:	Sex: Male Female	Race:
Address:		
City:	State:	Zip Code:

Phone Cell:	Home:	Work:	Preferred Contact Number Cell Home Work
Email address:		Social Security number:	
Preferred Pharmacy: Name and Location		Emergency Contact: Name and Phone	
Employed: Yes No		Marital Status:	

Release of PHI
As outlined in Kennestone Family Medicine's "Notice of Privacy Practices, we may disclose your **protected health information (PHI)** to individuals or entities involved in your healthcare. Provide the names of individuals you **do not** want to receive your PHI.

_____

_____

Release for treatment of a Minor
Except under certain legal exemptions, a parent or guardian signature is required for the treatment of a minor. I am the parent/guardian for

_____
Name of Minor and give Kennestone Family Medicine authorization to provide treatment.

_____
Parent/Guardian Signature

_____
Witness

Consent for Treatment and Payment
I consent to examination, diagnosis and medical care including office lab services (blood draws), injections to be performed by providers and employees of Kennestone Family Medicine. **I understand that I am ultimately responsible for all fees for services rendered that are not covered by insurance.**

_____
Patient Signature

_____
Date

No Show and Cancellation Policy: A charge of **$25** will be implemented for no show or late cancelled confirmed appointments. Insurance will not cover these fees; therefore, they will not filed with your insurance company. Please call 24 hours in advance to reschedule or cancel your appointment. We understand that circumstances beyond your control may arise, in this case please call as soon as you can.

Name: _____ DOB:_____/_____/_____

May we discuss medical/billing information with another person other yourself; if so please list

1._____ phone:_____

Please fill out the following information so that we have an understanding of your current medical status
Current Medications (name of the drug and dosage):

1._____ 2._____

3._____ 4._____

Drug Allergies Please check or list drugs and the type of reaction:

☐ List any drug allergies: _____

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

☐ High Blood Pressure	☐ Cancer	☐ Asthma	☐ Glaucoma/cataract
☐ Diabetes	☐ Depression/anxiety	☐ Headache/migraine	☐ Dementia/memory loss
☐ Heart Disease	☐ Anemia	☐ COPD	☐ Seizure Disorder
☐ High cholesterol	☐ Stroke/TIA	☐ Fibromyalgia	☐ Positive HIV/AIDS
☐ Acid reflux	☐ Hepatitis-B/C	☐ Gout	☐ Sexually transmitted diseases
☐ Thyroid disease	☐ DVT/PE	☐ Arthritis	☐Other(Describe):_____

Past Surgery:

1._____ 2._____

3._____ 4._____

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/week? _____

Family History:

Do you have a family history of: **High Blood Pressure**: ☐ Yes ☐ No **Heart Disease**: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No **Cancer**: ☐ Yes ☐ No **Mental disease**: ☐ Yes ☐ No **Other**: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
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	☐	☐	☐	☐

Total Score: _____

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

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐