Gwinnett Medical Center
Brain and Spine Institute
Patient Registration Form

PAIENT REGISTRATION

NAME(Last,First,Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If applicable)
CITY,STATE,ZIP	CITY,STATE,ZIP
HOME PHONE	CELL PHONE
MAY WE CONTACT YOU THROUGH EMAIL ❑ Y ❑N	EMAIL ADDRESS
PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS	ADDRESS
CITY,STATE,ZIP	CITY,STATE,ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If different than above)

NAME (Last,First,Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS(If applicable)
CITY,STATE,ZIP	CITY,STATE,ZIP
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #
NAME OF INSURED	**DATE OF BIRTH**	GROUP #
ADDRESS OF INSURANCE		COPAY AMOUNT
CITY,STATE,ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

SECONDARY INSURANCE (If applicable)

NAME OF INSURANCE COMPANY		POLICY #
NAME OF INSURED	**DATE OF BIRTH**	GROUP #
ADDRESS OF INSURANCE		COPAY AMOUNT
CITY,STATE,ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

PLEASE TURN FORM OVER AND COMPLETE THE REMAINING INFORMATION ON THE BACK. PLEASE SIGN ON THE FRONT AND THE BACK

SIGNATURE OF PATIENT/GUARDIAN	DATE

Marital Status: Single____ Married____ Widowed____ Legally Separated____Divorced____

Student Status: Not a Student____ Full-time Student____ Part-time Student____

EMERGENCY CONTACT	
NAME	RELATIONSHIP
HOME PHONE NUMBER	DAYTIME PHONE NUMBER
GUARANTOR EMPLOYMENT INFORMATION	
EMPLOYER NAME	
WORK PHONE NUMBER	EXTENSION
INSURANCE INFORMATION	
PRIMARY INSURED EMPLOYER (If different from patient employer)	
SECONDARY INSURED EMPLOYER (If applicable)	

Medicare Part B Beneficiaries:

Do you have Medicare Part B due to: Age_____ Disability_____ End-Stage Renal Disease_____
Are you employed? No_____ Yes_____ *Number of employees_____
Do you have employer group health plan coverage? No_____ Yes_____
Is your spouse employed? No_____ Yes_____ *Number of employees_____
Are you covered trough your spouse's insurance? No_____ Yes_____

*If twenty (20) or more employees, then Medicare is secondary payer. If disabled and under age 65, if one hundred (100) or more employees, Medicare is secondary.

SOCIAL/SPIRITUAL/CULTURAL:

Occupation: ________________________ ❑ Retired ❑ Other: ______________________________
Learning Preferences: ❑ Verbal/Listening ☐ Written/Reading ☐ Demonstration ☐ No preference
Communication needs or religious/spiritual/cultural beliefs that will affect your care? ❑ Y ❑ N
Explain: ____
Tobacco use: ❑ **None** Amount per day ______ years ______❑ Date stopped _______❑ Advised not to smoke
Recreational drugs: ❑ **None** Type (amount/frequency) ________________________
Alcohol: ❑ **None** Type (amount/frequency): ________________ last drink: _______
Do you have any body piercing jewelry? ❑ Y ☐ N Location: ____________________________________
Sleep Problems: ❑ **None** ❑Excessive daytime sleepiness ☐ Loud snoring ☐Long pauses during sleep
Do you feel safe returning home? ❑ Y ❑N Explain: ____________________________________
Do you feel that you have been abused, neglected, or exploited by someone close you? ❑Y ❑ N
Explain: ____
Religious Preference: ____

WHO MAY WE THANK FOR YOUR REFERRAL?

Referred By	Ins. Directory	Friend
Yellow Pages	Direct Mail	Website
Physician	Other	

Please be prepared to pay for office visits at the time of your appointment. Our office accepts cash, check or credit card.

SIGNATURE OF PATIENT/GUARDIAN DATE

The Brain & Spine Institute at Gwinnett Medical Center

GENERAL MEDICAL QUESTIONNAIRE

NAME: ________________________________ DATE ________________

PAST MEDICAL HISTORY

A/ SURGERIES/ HOSPITALIZATIONS (include month & year):

____
____
____
____

B/ MEDICAL CONDITIONS:
Have you ever had any of the following diseases (circle as appropriate)?
Blood disorders / DVT / Clotting problems / Cancer / Chemical dependency / HIV or AIDS/ Emotional problems / Stomach ulcers / Heart disease / High blood pressure / Kidney disease / Arthritis / Liver disease / Pneumonia / Asthma / Problems with the stomach or bowels / Rheumatic fever / Thyroid disease / Tuberculosis / Diabetes / Emphysema / Epilepsy / Hepatitis / High cholesterol / Multiple sclerosis / Pacemaker / Ankylosing spondylosis/ Reiter syndrome / Psoriasis / Irritable bowel syndrome
Other problems: ____
____
____
____

C/ MEDICATIONS (fill separate medication intake sheet)

D/ ALLERGIES & INTOLERANCES:
Please list all drugs or substances that you cannot tolerate or are allergic to.

____
____

FAMILY HISTORY

Circle the medical conditions that apply to family members.
CANCER: Mother / father / brother / sister / grandparent / aunt & uncle
DIABETES: Mother / father / brother / sister / grandparent / aunt & uncle
HEART DISEASE: Mother / father / brother / sister / grandparent / aunt & uncle
HIGH BLOOD PRESSURE: Mother/ father / brother / sister / grandparent / aunt & uncle
TUBERCULOSIS: Mother / father / brother / sister / grandparent / aunt & uncle

HEALTH: FATHER: good/ bad / died, MOTHER: good/ bad / died
BROTHER(S): good/ bad / died, SISTER(S): good/ bad / died

SOCIAL HISTORY

Occupation: ____

Marital status: [Single] [Married] [Divorced] [Widowed]

Do you smoke? No / Yes How many packs/day: ___If you quit, give date: __/__/__

Do you drink alcohol? No / Socially / More (drinks/day _____)

Do you use illegal drugs? No / Yes (which one? ______________________)

Do you exercise regularly? Yes / No

Relative(s) or others you live with? ________________________________

REVIEW OF SYSTEMS

(circle all that apply):

1/ CONSTITUTIONAL: Appetite change / weight change / fever / chills / malaise / fatigue

2/ SKIN: Itching / rash / hives / skin cancer / easy bruising

3/ ALLERGY/IMMUNE: Cancer / seasonal allergies / asthma

4/ ENT: Hearing changes / ringing / nose bleeds / hoarseness

5/ EYES & HEAD: Vision changes/ headaches / dizziness

6/ RESPIRATORY: Shortness of breath / cough / wheezing

7/ CARDIOVASC: Chest pain / edema / fainting / varicose veins / swollen ankles

8/ GI: Indigestion & heartburn / belly pain / diarrhea / constipation / blood in stools / bowel changes

9/ GU: Pain when urinating / blood in urine / difficulties urinating / discharge / erection problems (men)

10/ ENDOCRINE: Breast mass (lump) or discharge / diabetes / steroid use

11/ MUSCULOSKELETAL: Bursitis / gout / stiffness / osteoporosis / weakness / numbness

12/ NEURO: Seizures / stroke / paralysis / speech problems

13/ PSYCHIATRIC: Anxiety / depression / stress

14/ HEME/LYMPH: Anemia / bruise easily / bleeding / swollen glands

OTHER: ____

PATIENT SIGNATURE: ____________________________ DATE: __________

For physician only

Reviewed with patient.

PHYSICIAN SIGNATURE: __________________________ DATE: __________

Reviewed 4/17/09

Gwinnett Hospital System

PLACE LABEL HERE

DESIGNATION OF PERSONAL REPRESENTATIVE

As a patient, you may designate one or more personal representatives. A personal representative may receive Protected Health Information (PHI) about you. PHI includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payments. Personal representatives will not have access to PHI in the periods that are between treatments or admissions.

A personal representative may be a spouse, relative, domestic partner, or friend. You can remove or add personal representatives at any time, including during treatment or upon another admission to a Gwinnett Hospital System facility.

____
(Patient Name)

_______________________________________ _____________________
(Street Address) *(Medical Record Number)*

_______________________________________ _____________________
(City, State, Zip) *(Telephone Number)*

☐ I do not wish to designate a personal representative. I understand that the hospital's healthcare team may designate an interim personal representative, if designating a personal representative will expedite or enhance my care as a patient.

☐ I designate the following as my personal representative or representatives:

(Name of Personal Representative)	*(Relationship)*
(Address, if known)	*(Telephone number)*
(City, State)	
(Name of Personal Representative)	*(Relationship)*
(Address, if known)	*(Telephone number)*
(City, State)	
(Name of Personal Representative)	*(Relationship)*
(Address, if known)	*(Telephone number)*
(City, State)	
(Name of Personal Representative)	*(Relationship)*
(Address, if known)	*(Telephone number)*
(City, State)	

_______________________________________ _____________________
Patient Signature Date

Gwinnett Hospital System

PLACE LABEL HERE

HOME MEDICINE LIST – OUTPATIENT SERIES/CLINIC
(MEDICATION RECONCILIATION)

ALLERGIES (Medicine, food, iodine) and describe reaction	❑ **No Known Allergies**

Date/ Initials	**Medicine Name** Include prescriptions, over the counter medicines, herbals, vitamins	**Dose** How many mg, mcg?	**How Often?** Once a day, before meals	**Comments or Changes** Patient's Pharmacy Phone #____________
	❑ Patient takes no home medicines		❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	
			❑ Every day ❑ __times a day ❑ As needed ❑ Other______	

GHS Associate Use at Each Visit:

Date/ Initials	Time	Signature of GHS Associate Reviewing Home Medicines

Date/ Initials	Time	Signature of GHS Associate Reviewing Home Medicines

If this visit resulted in a medication change, fax form to the next provider(s) and give a copy to the patient.

Date	Next Provider	Fax Number

Date	Next Provider	Fax Number

FORM 1-21424 REV. 07/2009 WHITE: Medical Record CANARY: Patient Copy at Initial Visit

OTC Only: Fax copy to Pharmacy Dept

Gwinnett Hospital System

PLACE LABEL HERE

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: Do not sign this form without reading and understanding its contents.
I hereby apply for and consent to admission and treatment by this Hospital and its Medical Staff, and authorize all routine hospital activities, treatments, examinations, and diagnostic services. During the course of my care and treatment, I understand that various types of tests and diagnostic treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, rang of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as those done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tube** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

PLACE LABEL HERE

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures;
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;
- The physicians, dentists, oral surgeons, podiatrists and psychologists at Gwinnett Hospital System are independent contractors of the Hospital and are not its employees or agents. As independent contractors, the physicians, dentists, oral surgeons, podiatrists and psychologists are responsible for their own actions; and
- I may withdraw my consent for **any** test or procedure at **any** time.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;**
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- I consent to the observation and participation of personnel-in-training and students in my care and treatment.
- I consent to the disposal by hospital authorities of any specimens, tissue or parts that may be removed from my body during my hospitalization.

  If you have a different request for the handling of any of these specimens, tissues, or parts please speak to your nurse. For disposition of fetal remains use Attachment E of Policy 7009-02 Fetal Death. For all other tissues please use the GHS Request and Authorization form for release. See Attachment F of Policy 7009-02.

- **If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information.** I also understand that my physician may ask me to sign additional Informed Consent documents.

Patient/Patient's Representative	Date
Relationship if other than self	Reason Patient is unable to sign (if applicable)
Witness	Date

For Gwinnett Hospital Use Only:
INTERPRETIVE SERVICE USED ON THIS ENCOUNTER

Interpreter used - Name or Number________________________________

Date/Time____________________ Language ____________________