ID# _____

Lifetime MEDICAL CENTER P.C. | PRIVIA MEDICAL GROUP

Patient Information

Last Name _____
First Name _____
Middle Name _____
Former Last Name _____
Sex _____
DOB _____
SSN _____
Address _____
Address 2 _____
Zip _____
City _____
State _____
Home phone _____
Mobile phone _____
Work phone _____
Email (required) _____
Preferred Pharmacy _____
Contact preference (please circle): HOME MOBILE WORK
Language _____
Race _____
Ethnicity _____
Marital Status _____
Homebound? YES NO

How did you hear about us? **(please circle options below)**

Advertising Primary Care Physician Specialist Physician Word of Mouth

Insurance Patient in Practice Hospital Insurance Co. Other

Specify (if Other, above) _____

Today's Date _____

Guardian

Last Name _____
First Name _____
Middle name _____

Emergency Contact

Name _____
Relationship _____
Home phone _____
Mobile phone _____

Next of Kin

Name _____
Relationship _____
Phone _____

Employment

Employer name _____
Employer phone _____

Guarantor Information

Last Name _____
First Name _____
Middle name _____
DOB _____
Address _____
Address 2 _____
Zip _____
City _____
State _____

Optional Information

Phone _____

___ Scanned

___ History Entered

Appointment: _____

_____

ID #

Lifetime MEDICAL CENTER P.C. | PRIVIA MEDICAL GROUP

Primary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Secondary Insurance Information

Insurance Plan Name _____

ID/Certification No. _____

Policy/Group No. _____

Primary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Secondary Policy Holder (if other than patient)

Patient's Relationship to policy holder: _____

Last Name _____

First Name _____

Middle Name _____

Address _____

Address (ctd) _____

City _____

State _____

Zip _____

Date of Birth _____

Policy Holder Sex _____

Employer Name _____

Patient Signature: _____ **Date:** _____

ID# _____

Lifetime MEDICAL CENTER P.C. | PRIVIA MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Privia to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay Privia directly, I agree to forward to Privia all health insurance payments which I receive for the services rendered by Privia and its health care providers. I authorize Privia or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate in the Privia network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of the services provided by Privia and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse Privia for all costs, expenses and attorney's fees incurred by Privia to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment

As a Privia patient, I voluntarily consent to the rendering of such care and treatment as Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff have made any guarantee or promise as to the results that may be obtained.

Consent to Call, Email & Text

I understand and agree that Privia may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia. I understand that I may opt-out of receiving such communications from Privia and its partners by notifying Privia at privacy@priviahealth.com, by informing my provider's staff or by visiting "My Profile" on my Privia Patient Portal.

HIPAA.

I understand that Privia's Privacy Notice is available at priviahealth.com/hipaa-privacy-notice and my care center's website and that I may request a paper copy at my care center's reception desk.

I hereby acknowledge that I have received Privia's Financial Policy and Privia's Notice of Privacy Practices. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with Privia providers.

Printed Name of Patient **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.**

Lifetime
MEDICAL CENTER P.C.

14244 HIGHWAY 515 N.
SUITE 100
ELLIJAY, GA 30536
(706) 698-5433 FAX (706) 698-5445

AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone#: _____

Release information from: _____ Phone #: _____

City: _____ State: _____ Fax #: _____

Release information to: Dr. Alana Kent Phone #: 706-698-5433

Fax #: 706-698-5445

I, the undersigned patient/guardian, hereby authorize the Dr. releasing records listed above, to release information listed below, from the records of patient listed above.

Please release the following information- ☒ **check all that apply**

- ☐ Progress Notes
- ☐ Labs
- ☐ x-rays
- ☐ Hospital
- ☐ Immunizations
- ☒ Other- Past 5 years

By signing this release, I agree to pay any fees that pertain to the release of my medical records. I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental illness, Drug / Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance thereof.

_____ _____

Signature of Patient / Guardian Date

_____ _____

Relationship to Patient Signature of Witness

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____
- ☐ MMR *(Measles, Mumps, Rubella)* Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap *(Tetanus and pertussis)* Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax *(Shingles)* Date:_____

☐ Sexually active

Current sexual partner is ☐ Female ☐ Male

Do you use condoms ☐ Yes ☐ No

Other Birth control method used:_____

☐ Interested in being screened for STDs

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

☐ Cesarean sections If yes, then number: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
1.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level ☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine ☐ None ☐ Occasional
☐ Moderate ☐ Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes -____pks./day
☐ Chew - ____/day
☐ Cigars - _____/day
☐ # of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____