SUGARLOAF MEDICAL P.C.
Internal Medicine Primary Care
1300 Peachtree Industrial Blvd., Suite 4201, Suwanee, GA 30024 (P) 770·831·3018 (F) 770·831·3669

NEW PATIENT PACKET

Welcome to Sugarloaf Medical!

We appreciate your decision to choose our team, and we aim to make your onboarding process as seamless as possible. To ensure that we provide you with the best possible care, we kindly request that you complete our new patient registration forms. These forms are specifically designed to gather essential information about your demographics and medical history, as well as ensuring your understanding and agreement to the following policies:

- Acknowledgement and Agreement: Patient Documents
  - ✓ Treatment Agreement and Financial Policy
  - ✓ Information on Annual Preventive Visits
  - ✓ Notice of Privacy Practices

Once again, thank you for choosing Sugarloaf Medical. We're excited to have you as part of our practice, and we're committed to delivering exceptional healthcare.

Warmly,
The Sugarloaf Medical P.C. Team

SUGARLOAF MEDICAL P.C.
Internal Medicine Primary Care

(P) 770·831·3018 (F) 770·831·3669
1300 Peachtree Industrial Boulevard,
Suite 4201, Suwanee, GA 30024

PATIENT

Last Name _____ First Name _____ Middle Name _____ Preferred Name _____

Date of Birth _____ Birth Sex: ☐ Female ☐ Male Social Security Number _____

Email _____ Cell Phone _____ Home Phone _____

Street Address _____ Apt # _____ City _____ State _____ Zip Code _____

Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native Other: _____

Would you like to opt out of paper statements?
☐ Yes ☐ No

EMERGENCY CONTACT & RELEASE OF PHI

Last Name, First Name _____ Phone Number _____ Relationship _____

Person who we may discuss your Protected Health Information (PHI) with:

☐ Same as Emergency Contact ☐ None ☐ Other (Provide information below)

Last Name, First Name _____ Phone Number _____ Relationship _____

PHARMACY

LOCAL PHARMACY

Pharmacy Name _____ Street Address _____ City _____ State _____ Zip Code _____

MAIL-IN PHARMACY

Pharmacy Name _____ Street Address _____ City _____ State _____ Zip Code _____

INSURANCE

☐ **SELF- PAY**

PRIMARY INSURANCE

Insurance Name _____ ID/Subscriber Number _____ Group Number _____

SECONDARY INSURANCE

Have you completed the Coordination of benefits process? ☐ **YES** ☐ **NO** (If no, please call your health plan to complete COB* **before** visit)

*The coordination of benefits (COB) is when insurance plans determine their payment responsibilities. This involves deciding which plan pays first (primary) and how much the other plan(s) (secondary) will contribute to your health expenses.

Insurance Name _____ ID/Subscriber Number _____ Group Number _____

Patient's Name _____ **Date of Birth** _____

CURRENT MEDICATIONS

Please list ALL current prescription medications you are taking including dosage and frequency: (Example: Lisinopril 10 mg Daily)

☐ **No medications taken**

Medication/Vitamin/Supplement	Dose	Frequency	Medication/Vitamin/Supplement	Dose	Frequency

ALLERGIES & INTOLERANCES

Please list ALL medication allergies, side effects and intolerances:

☐ **No known allergies or intolerances**

Medication/Substance	Reaction

SOCIAL HISTORY

SMOKING:

☐ Never Smoked

☐ Current Smoker **Packs per day?** _____ **For how many years?** _____

☐ Previous Smoker **Packs per day?** _____ **For how many years?** _____ **Quit Date:** _____

ALCOHOL USE:

☐ NO

☐ YES **How often?** _____
Socially, daily, etc.

Patient's Name _____ **Date of Birth** _____

MEDICAL HISTORY

Have you ever been diagnosed with any of the following chronic medical conditions?

CARDIOLOGY
- ☐ High Blood Pressure
- ☐ High Cholesterol or Triglycerides
- ☐ Coronary Artery Disease (CAD) (Heart Attack)
- ☐ Congestive Heart Failure (CHF)
- ☐ Atrial Fibrillation (A-Fibb)
- ☐ Supraventricular Tachycardia (SVT)
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Stroke or Transient Ischemic Attack (TIA)

RESPIRATORY & ALLERGY
- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Asthma (Exercise Induced)
- ☐ Chronic Obstructive Pulmonary Disease/ Emphysema
- ☐ Obstructive Sleep Apnea

ONCOLOGY/NEOPLASMS
- ☐ Cancer of the Lung
- ☐ Cancer of the Colon
- ☐ Cancer of the Skin
- ☐ Cancer of the Breast
- ☐ Cancer of the Cervix
- ☐ Cancer of the Uterus
- ☐ Cancer of the Ovary
- ☐ Cancer of the Prostate
- ☐ Cancer of the Urinary Bladder
- ☐ Cancer of the Thyroid
- ☐ Hodgkin Lymphoma
- ☐ Non-Hodgkin Lymphoma
- ☐ Leukemia
- ☐ Polycythemia Vera

PSYCHIATRY
- ☐ Generalized Anxiety Disorder
- ☐ Panic Attack(s)
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Obsessive Compulsive Disorder
- ☐ Major Depression, Single Episode
- ☐ Major Depression, Recurrent
- ☐ Bipolar Disorder
- ☐ Attention Deficit Hyperactivity Disorder (ADHD/ADD)

ENDOCRINOLOGY
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Hypothyroidism* Autoimmune (Hashimoto's)
- ☐ Hypothyroidism* Post Thyroidectomy
- ☐ Hypothyroidism* Post Radioiodine Therapy
- ☐ Hyperthyroidism* (Graves' Disease)
- ☐ Thyroid Nodule(s)
- ☐ Hyperprolactinemia
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Osteoporosis
- ☐ Osteopenia

RHEUMATOLOGY
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Systemic Lupus Erythematosus (SLE)
- ☐ Sjogren's Syndrome

INFECTIOUS DISEASE
- ☐ Genital Herpes
- ☐ Cold/Fever Sore
- ☐ Hepatitis B Infection
- ☐ Hepatitis C Infection
- ☐ Human Immunodeficiency Virus (HIV)

HEMATOLOGY
- ☐ Iron Deficiency
- ☐ Vitamin B12 Deficiency
- ☐ Thalassemia Trait
- ☐ Sickle-cell Disease
- ☐ Sickle-cell Trait
- ☐ Clotting Disorder (Thrombophilia)
- ☐ Bleeding Disorder

NEUROLOGY
- ☐ Migraine Headaches
- ☐ Restless Leg Syndrome
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Primary Insomnia

GASTROENTEROLOGY
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Peptic Ulcer Disease (PUD)
- ☐ Eosinophilic Esophagitis
- ☐ Barrett's Esophagus
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulitis of Colon
- ☐ Irritable Bowel Syndrome (Constipation)
- ☐ Irritable Bowel Syndrome (Diarrhea)
- ☐ Irritable Bowel Syndrome (Mixed)
- ☐ Nonalcoholic Fatty Liver Disease
- ☐ Cirrhosis of the Liver
- ☐ Celiac Disease

GENITOURINARY
- ☐ Chronic Kidney Disease
- ☐ Urinary Incontinence
- ☐ Interstitial Cystitis
- ☐ Nephrolithiasis (Kidney Stones)
- ☐ Enlarged Prostate (BPH)
- ☐ Erectile Dysfunction
- ☐ Endometriosis
- ☐ Uterine Fibroids

SKIN
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

EYES
- ☐ Cataract
- ☐ Glaucoma

EARS, NOSE & THROAT
- ☐ Benign Paroxysmal Positional Vertigo
- ☐ Hearing Loss

ADDITIONAL DIAGNOSIS

_____
Diagnosis

_____
Diagnosis

_____
Diagnosis

Patient's Name _____ **Date of Birth** _____

SURGICAL HISTORY

Have you had any of the following surgeries or procedures?

EAR, NOSE, THROAT, HEAD & NECK

- ☐ Tonsillectomy/Adenoidectomy (Removal of Tonsils/Adenoids) _____ Year
- ☐ Septoplasty (Correction of deviated nasal septum) _____ Year
- ☐ Rhinoplasty (Nasal Construction) _____ Year
- ☐ Sinus Surgery _____ Year
- ☐ Cataract Surgery _____ Year
- ☐ Thyroidectomy (Removal of thyroid gland) _____ Year

THORASIC & VASCULAR

- ☐ Percutaneous Coronary Intervention ☐Stent ☐ Angioplasty _____ Year
- ☐ Heart valve repair or replacement ☐ Bioprosthetic ☐ Mechanical _____ Year
- ☐ Coronary Artery Bypass Grafting (Heart bypass surgery) _____ Year
- ☐ Implantable Cardioverter Defibrillator _____ Year
- ☐ Pacemaker _____ Year
- ☐ Carotid Endarterectomy (Blockage removal in carotid artery) _____ Year

GENERAL & COLORECTAL

- ☐ Appendectomy (Removal of appendix) _____ Year
- ☐ Colectomy (Removal of parts of the colon) _____ Year
- ☐ Cholecystectomy (Removal of gallbladder) _____ Year
- ☐ Hernia ☐ Inguinal ☐ Umbilical _____ Year

BARIATRIC

- ☐ Gastric Bypass _____ Year
- ☐ Sleeve Gastrectomy _____ Year

ORTHOPAEDIC

- ☐ Spine Surgery ☐ Spinal Fusion ☐ Microdiscectomy ☐ Laminectomy _____ Year
- ☐ Rotator Cuff Repair ☐ Left ☐ Right _____ Year
- ☐ Hip Replacement ☐ Left ☐ Right _____ Year
- ☐ Knee Replacement ☐ Left ☐ Right _____ Year
- ☐ ACL Repair ☐ Left ☐ Right _____ Year
- ☐ Arthroscopic Meniscus Repair ☐ Left ☐ Right _____ Year

OBSTETRICS/GYNECOLOGY

- ☐ Cesarean Section _____ Year(s)
- ☐ Tubal Ligation _____ Year
- ☐ Breast Reduction _____ Year
- ☐ Breast Implants _____ Year
- ☐ Hysterectomy ☐ Partial ☐ Complete _____ Year
- ☐ Mastectomy (Removing all or part of breast) _____ Year

UROLOGIC

- ☐ Prostatectomy (Removal of the prostate gland) _____ Year
- ☐ Nephrectomy (Removal of the kidney) _____ Year
- ☐ Bladder Surgery _____ Year
- ☐ Benign Prostatic Hyperplasia (BPH) (Enlarged prostate surgery) _____ Year

ADDITIONAL SURGERIES

_____ Surgery _____ Year

_____ Surgery _____ Year

_____ _____

Patient's Name **Date of Birth**

FAMILY HISTORY

FATHER

☐ **Alive** _____ Year of Birth _____ Age

☐ **Deceased** _____ Age of Death _____ Cause of Death

☐ **Unknown**

MOTHER

☐ **Alive** _____ Year of Birth _____ Age

☐ **Deceased** _____ Age of Death _____ Cause of Death

☐ **Unknown**

☐ **Unknown Family History, Adopted**

Please indicate if any of your immediate family members have or ever had any of the following medical conditions:

	Father (age/year diagnosed)	**Mother** (age/year diagnosed)	**Siblings** (age/year diagnosed)
Familial Hypercholesterolemia	☐ _____	☐ _____	☐ _____
Diabetes Mellitus	☐ _____	☐ _____	☐ _____
Coronary Artery Disease (Myocardial Infarction)	☐ _____	☐ _____	☐ _____
Bicuspid Aortic Valve	☐ _____	☐ _____	☐ _____
Sudden Cardiac Death	☐ _____	☐ _____	☐ _____
Polycystic Kidney Disease	☐ _____	☐ _____	☐ _____
Hypercoagulable Disorder (Blood Clotting)	☐ _____	☐ _____	☐ _____
Lung Cancer	☐ _____	☐ _____	☐ _____
Colon Cancer	☐ _____	☐ _____	☐ _____
Breast Cancer	☐ _____	☐ _____	☐ _____
Ovarian Cancer	☐ _____	☐ _____	☐ _____
Prostate Cancer	☐ _____	☐ _____	☐ _____

Please list any additional immediate family medical history below:

	Father (age/year diagnosed)	**Mother** (age/year diagnosed)	**Siblings** (age/year diagnosed)
_____ Diagnosis	☐ _____	☐ _____	☐ _____
_____ Diagnosis	☐ _____	☐ _____	☐ _____
_____ Diagnosis	☐ _____	☐ _____	☐ _____

Patient's Name _____ **Date of Birth** _____

REVIEW OF SYSTEMS

Do you <u>currently</u> or <u>regularly</u> experience any of the following symptoms?

CONSTITUTIONAL SYMPTOMS

- ☐ Often feel tired, fatigued, or sleepy during the daytime
- ☐ Loud Snoring (loud enough to be heard through closed door)
- ☐ Has anyone observed you stop breathing or choking/gasping during your sleep?
- ☐ Wake up feeling like you haven't slept

ENT & ALLERGY

- ☐ Breathing through the mouth due to obstruction of the nasal passages
- ☐ Runny nose, nasal congestion, sneezing or postnasal drip when exposed to allergens such as pollen, dust mites
- ☐ Hives, itching or bumps on the skin

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitations (Sensation of irregular, rapid and/or forceful beating of the heart)
- ☐ Shortness of breath upon exertion
- ☐ Shortness of breath when lying flat
- ☐ Fainting or passing out
- ☐ Lower extremity swelling

RESPIRATORY

- ☐ Cough, episodic or chronic
- ☐ Wheezing
- ☐ Chronic excessive sputum
- ☐ Coughing up blood

GASTROENTEROLOGY

- ☐ Recurrent discomfort in upper abdomen after eating
- ☐ Heartburn
- ☐ Food being stuck in throat or chest
- ☐ Blood in stool or darkened feces
- ☐ Changes in bowel movements
- ☐ Diarrhea, bloating, flatulence, and/or pain after ingestion of milk-containing products
- ☐ Chronic constipation
- ☐ Chronic diarrhea

GENITOURINARY

- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Inability to have or maintain an erection for sexual intercourse
- ☐ Premature ejaculation (sooner than you or your partner wishes is)
- ☐ Irregular menstrual cycle
- ☐ Postmenopausal vaginal bleeding
- ☐ Discharge from nipple
- ☐ Nipple retraction
- ☐ Lump in breast

SKIN

- ☐ Localized skin swelling, mass, or lump
- ☐ Enlarged lymph nodes

PSYCHIATRIC

- ☐ Feeling down, depressed, or hopeless
- ☐ Feeling nervous, restless, sense of impending danger, panic, or doom
- ☐ Little interest or pleasure in doing things
- ☐ Difficulty with organization skills, time management, following through and completing tasks

ADDITIONAL SYMPTOMS

_____
Sign/Symptom

_____
Sign/Symptom

_____
Sign/Symptom

Patient's Name _____ **Date of Birth** _____

GYNECOLOGY HISTORY

Last Pap Smear: _____ (Date) **Result:** ☐ Normal ☐ Abnormal

Last Mammogram: _____ (Date) _____ (Performing Facility) **Result:** ☐ Normal ☐ Abnormal

Last Bone Density Scan (DEXA): _____ (Date) _____ (Performing Facility) **Result:** ☐ Normal ☐ Abnormal

UROLOGIC HISTORY

Please complete if you are a male patient over 40 years old.

0-Not at all | **1**- Less than 1 time in 5 | **2**- Less than half the time | **3**- About half the time | **4**- More than half the time | **5**- Almost always

RATING SCALE	0	1	2	3	4	5
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	☐	☐	☐	☐	☐	☐
Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	☐	☐	☐	☐	☐	☐
Over the past month, how often have you stopped and started again several times when you urinated?	☐	☐	☐	☐	☐	☐
Over the past month, how often have you found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
Over the past month, how often have you had a weak urinary stream?	☐	☐	☐	☐	☐	☐
Over the past month, how often have you had to push or strain to begin urination?	☐	☐	☐	☐	☐	☐
Over the past month, how many times did you get up to urinate from the time you went to bed at night until the time you got up in the morning?	☐	☐	☐	☐	☐	☐

Score: _____

BPH Score Index: 0 to 7 Mild Symptoms | 8 to 19 Moderate Symptoms | 20-30 Severe Symptoms

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Internal Medicine Primary Care

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1300 Peachtree Industrial Boulevard,
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NEW PATIENT MEDICAL RECORDS REQUEST

INSTRUCTIONS:

To provide top-quality care for our patients, *we strongly encourage* our patients to have *all* their medical records from the last 5 (five) years sent to our office. This is especially important for our New Patients, to provide the best starting place for your care.

This includes, *but is not limited to:*

- Hospital stays,
- Radiology reports,
- Your prior primary care physicians records, and
- Specialty care you have received.

To help you stay organized, please complete an *Authorization to Request* for each current and prior (*last 5 years*) healthcare providers below to send medical records requests to:

SUGARLOAF MEDICAL P.C.
Internal Medicine Primary Care

(P) 770·831·3018 (F) 770·831·3669
1300 Peachtree Industrial Boulevard,
Suite 4201, Suwanee, GA 30024

AUTHORIZATION TO *REQUEST* YOUR PROTECTED HEALTH INFORMATION

Patient Information:

_____ _____
Patient's Name Date of Birth

_____ _____ _____ _____
Street Address City State Zip Code

Sender:

_____ _____
Physician's Name Facility Name

Specialty:
☐ Primary Care Physician
☐ Specialist: _____

_____ _____
Phone Number Fax Number

_____ _____ _____ _____
Street Address City State Zip Code

Recipient: Sugarloaf Medical, P.C.

FOR SENDER'S USE:

Electronic Health Records (EHR) Transfer Methods:

- eClinicalWorks : Physician to Physician (P2P)
- Other Direct EHR : sugarloaf.medical@smimpc.eclinicaldirectplus.com

Mail a copy to:
Sugarloaf Medical, P.C.
1300 Peachtree Industrial Blvd., Suite 4203,
Suwanee, GA 30024

Fax a copy to: (770)831-3669

Health Information to Be Released (PLEASE DO NOT SEND ENTIRE RECORD)**:**

Please submit medical summary and relevant diagnostic reports from the last 5 years.

Signature:

I am either the patient named above or the patient's legally authorized representative. By signing this form, I hereby authorize the sender to release the selected health information. I understand, acknowledge, and agree that:

- My medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information; I specifically agree to its release;
- Unless revoked, this authorization will expire on the following date or event, or one year from date of signature, unless otherwise specified;
- Once information is released to the above-named person or persons, my information may be subject to re-disclosure subject to specific restrictions on redisclosure as set forth below;
- I understand that the records may be provided to copy services for the sole purpose of copying said records.
- I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed;
- I authorize the use and disclosure of the protected health information specified above;
- I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The authorization for Release of Information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibits information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient;
- I am fully responsible for the fees, if any, brought by this request;
- I may revoke this authorization in writing at any time, but that such revocation will not apply to information that has already been released.

I can mail this written revocation to:

Attention: Sugarloaf Medical, P.C. Medical Records Department
1300 Peachtree Industrial Blvd., Suite 4203, Suwanee, Georgia 30024

Signature of Patient or Legally Authorized Representative *and relationship to patient*

Date

SUGARLOAF MEDICAL P.C.
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1300 Peachtree Industrial Blvd., Suite 4201, Suwanee, GA 30024 (P) 770·831·3018 (F) 770·831·3669

ACKNOWLEDGEMENT AND AGREEMENT: NEW PATIENT PACKET

I hereby acknowledge and agree that I have carefully read and considered the provisions of the ***Treatment Agreement and Financial Policy*** located on Sugarloaf Medical's website **(sugarloafmedical.com/forms)** as of the date set forth below, and I sign the same of my own free act.

Signature of Patient or Legally Authorized Representative — Date of Birth

Print Name of Patient or Legally Authorized Representative *(and Relationship to Patient)* — Date

I hereby acknowledge and agree that:

- I have received the following titled documents from Sugarloaf Medical, P.C. (collectively, the "New Patient Packet"):
    1. New Patient Intake Forms
        a. Patient Demographics and Insurance Information Form
        b. Medical History Form
    2. Medical Records Request Form
- I have reviewed the following titled documents located on Sugarloaf Medical's website **(sugarloafmedical.com/forms)**:
    1. Notice of Privacy Practices
    2. Information on Annual Preventive Visits
- I have carefully read and reviewed the New Patient Packet in its entirety.
- I have completed the New Patient Intake Forms.; *and*
- The information I have provided to Sugarloaf Medical, P.C. when completing the New Patient Packet is correct, accurate, and complete to the best of my knowledge.

I agree to abide by all policies, procedures, terms, and conditions contained in the New Patient Packet.

Signature of Patient or Legally Authorized Representative — Date of Birth

Print Name of Patient or Legally Authorized Representative (*and Relationship to Patient)* — Date

REMAINDER OF PAGE IS INTENTIONALLY LEFT BLANK