WELLSTAR Medical Group
Ear, Nose & Throat

Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name		Date of Birth	Age	Patient Gender ❒ M ❒ F
Street Address	City	State	Zip Code	Social Security Number	
Home Telephone ❒ check box if primary	Work Telephone ❒ check box if primary	Cell Telephone ❒ check box if primary	Email Address		
Need Interpreter? ❒ Yes ❒ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ❒ Yes ❒ No	Race	Religion
Activate MyChart ❒ Yes ❒ No	Employer Name		Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student		
Employer Address	City	State	Zip Code	Employer Telephone	
Emergency Contact Last Name	First Name		Pharmacy Telephone Number		

Emergency Contact Relation to Patient	Legal guardian? ❒ Yes ❒ No	Hearing Impaired? ❒ Yes ❒ No	Visually Impaired? ❒ Yes ❒ No	Home Telephone ❒ check if primary	Work Telephone ❒ check if primary	Cell Telephone ❒ check if primary

Primary Care Physician

2. Responsible Party / Guarantor ❒ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code
Guarantor Relation to Patient	Guarantor Gender ❒ M ❒ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ❒ Full-time ❒ Unemployed ❒ Disabled ❒ Part-time ❒ Retired ❒ Student			Employer Telephone	

3. Medical Insurance Policy Holder ❒ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

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WMG Patient Registration Form - page 2

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WellStar Medical Group to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Consent to Contact

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Signature of Patient / Legal Guardian:	Date:

WELLSTAR Medical Group
Ear, Nose & Throat

COORDINATION OF BENEFITS INFORMATION WORKSHEET

Member ID #: _____
Patient Name: _____
Provider Name: _____

In order to provide timely processing of claims, WellStar Health System has completed the Coordination of Benefits (COB) information in conjunction with the member mentioned above or the guarantor of such member.

1. Are you or any of your family members covered under another policy in addition to _____ which is the insurance currently listed as your coverage for this visit?

   If "YES", please complete the information listed below. If other coverage is Medicare, skip to item 3. If "NO", please skip to Item 4.

   Name of Primary Policyholder: _____ Policy ID Number: _____
   Name of Other Insurance Carrier: _____ Phone: _____
   Employer Group Name and Number: _____ Policyholder Date of Birth: _____
   Effective Date of Other Coverage: _____

   Type of Other Health Insurance Plan (check all that apply):
   ❒ Medical ❒ Prescription ❒ Dental ❒ Vision

   Please identify who is covered under the other policy:
   Name: _____ Relationship to Policyholder: _____
   Name: _____ Relationship to Policyholder: _____
   Name: _____ Relationship to Policyholder: _____
   Name: _____ Relationship to Policyholder: _____

2. If dependent children are covered under another policy, is there any court-ordered coverage?
   ❒ Yes ❒ No *If yes, please provide the name of the child and the name of the parent or guardian responsible for coverage:*

Name of Child:	Person Responsible for Coverage:	Relationship:

   If there is no court order, who has custody of the child? _____

3. Medicare Coverage Information:

Name	Actively Employed?	Part A effective date	Part B effective date	Medicare Number
	YES or NO			
	YES or NO			

Is Medicare related to End-Stage Renal (Kidney) Disease (ESRD)? If so, please provide the first date of renal dialysis: _____

4. I certify that the above information is correct:

Patient Signature: _____ Date: _____ Phone #: _____

WellStar Health System
805 Sandy Plains Road
Marietta, GA 30066
Customer Service Phone # 470-245-9998

WellStar

❒ AMC ❒ AMC South ❒ Cobb ❒ Douglas
❒ Kennestone ❒ North Fulton ❒ Paulding ❒ Spalding
❒ Sylvan Grove ❒ West Georgia ❒ Windy Hill ❒ _____

Coordination of Benefits Information Worksheet

WELLSTAR Medical Group
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Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name *First Name* *Middle Initial* *Date of Birth (Month / Day / Year)*

Street Address *Apt. # / P.O. Box # (Please include complete mailing address)* *Medical Record # / Social Security # (optional)*

City *State* *Zip Code* *Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number *Cell Phone Number* *Other Phone Number*

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ Parent: *Name* *Relationship* *Phone Number*

☐ Other: *Name* *Relationship* *Phone Number*

☐ Other: *Name* *Relationship* *Phone Number*

☐ Other: *Name* *Relationship* *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) *Month / Day / Year*

Print Patient Name or Name of Legal Guardian / Personal Representative ***Signature of Patient or Legal Guardian / Personal Representative***

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

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Acknowledgment of Receipt

"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have received a copy of WellStar Health System's ***"Notice of Privacy Practices"*** for protected health information on the date set forth below.

Date of Receipt

Patient Date of Birth

Print Patient Name

Print Name of Authorized Personal Representative

Patient Signature

Signature of Authorized Personal Representative

Please indicate relationship to patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY

*(complete if patient acknowledgement is **not** obtained)*

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication / language or other barrier
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (*please indicate reason)*: _____

Signature of WellStar Representative

Date

WellStar Medical Group

Acknowledgment of Receipt of Notice of Privacy Practices

WELLSTAR Medical Group
Ear, Nose & Throat

Dear Valued Patient:

Thank you for selecting the WellStar Medical Group. We are honored that you have chosen us as your health care provider. Our goal is to provide you and all of our patients with the highest-quality, individualized medical care in a timely and respectful manner.

Our commitment to our patients is that we will do our best to provide same-day access for sick visits and will make every attempt to see you at your appointment time for routine scheduled appointments. Last minute cancellations and not arriving on time for appointments are an inconvenience that affects other patients who are scheduled to be seen that day. We have developed a WellStar Medical Group policy regarding no-shows and late cancellations in order to help us meet our goal. Having such a policy enables us to better utilize available appointments for all of our patients in need of medical care.

Cancellation of an Appointment

If you are unable to keep your appointment, please call your WMG healthcare provider's office promptly, so that this time can be reallocated to someone who is equally in need of care. If you must cancel your scheduled appointment, we require that you call at least 24 hours in advance if you are seeing a primary care physician (Internal Medicine, Family Practice, Pediatrics or ObGyn) or at least 48 hours in advance if you are seeing a specialist. Appointments are in high demand, and your early cancellation will give another person access to that appointment time. A **late cancellation** is when a patient fails to cancel his or her scheduled appointment with 24-hours advance notice for primary care or 48-hours notice for specialty care.

How to Cancel Your Appointment

To cancel appointments, please call your WMG healthcare provider's office, or utilize MyChart's "Appointments – Cancel an Appt" function.

Missed Appointment or "No-Show"

A **no-show** is someone who misses an appointment without cancelling it at least 24 hours in advance for a primary care visit or at least 48 hours for a specialty visit. Failure to be present at the time of a scheduled appointment, or arriving 15 minutes or more after your scheduled appointment, will be recorded as a no-show. Patients may be subject to dismissal from the practice on the third occurrence of a missed appointment or no-show, or a combination of either.

Again, we appreciate you placing your trust in the WellStar Medical Group for your healthcare needs.

Sincerely,

WellStar Medical Group

Patient Name: _____ DOB:_____

Patient Signature: _____ Date:_____

WELLSTAR Medical Group
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Adult and Pediatric Intake Form

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Height _____ Weight _____

Pharmacy Name: _____ Pharmacy Phone number _____

Reason for visit: _____

Have you had any tests/surgeries for this problem? _____

_____

Who referred you to us?

☐ Primary care physician

☐ Other Physician(s) Name: _____

☐ Non Physician health care provider Name: _____

☐ Phonebook/other Detail: _____

☐ Friend/family

PAST MEDICAL HISTORY (Please Mark all that Apply)

Check if you have a history of: (provide year of diagnosis if known) ☐ No Past Medical History

☐ ADHD ____
☐ Alcoholism_____
☐ Allergies_____
☐ Anemia_____
☐ Anxiety_____
☐ Arthritis _____
☐ Asthma_____
☐ Blood clots_____
☐ Bronchitis_____
☐ Cancer type _____
☐ Congestive heart failure_____
☐ COPD_____
☐ Coronary artery disease or Heart Attack_____
☐ CVA (Stroke) _____
☐ Depression_____
☐ Diabetes Type_____ Insulin/Med_____
☐ Emphysema_____
☐ Fibromyalgia_____
☐ Glaucoma _____
☐ GERD (Reflux)_____
☐ Hepatitis A, B, or C _____
☐ High Cholesterol_____
☐ HIV_____
☐ Hypertension_____
☐ Kidney Disease _____
☐ Mitral Valve Prolaspe _____
☐ Pneumonia _____
☐ Seizures _____
☐ Sickle Cell _____
☐ Sleep apnea_____
Check if you use: ☐ CPAP/BiPAP
☐ Systemic lupus erythematosus_____
☐ Toxic exposures_____
☐ Hyperthyroid disease_____
☐ Hypothyroid disease_____
☐ Tuberculosis_____

Other not listed above:

_____ _____
_____ _____
_____ _____
_____ _____

Name: _____ Date of Birth: _____ Today's Date: _____

Please list all surgeries or procedures you have had:

☐ No Previous Surgeries

Date	Type of Surgical Procedure	Hospital

Please list all medications including inhalers, herbals and vitamins you are taking:

☐ See List (If You Provided List)

Name	Dose/Strength	How often do you take?

☐ See Additional (Use Additional Sheet if Necessary)

Advance directives in place:

☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney

ALLERGIES

Please list all drug allergies:

Allergic To:	Reaction

FAMILY HISTORY

☐Check here if family history not available

Diagnosis	Mother	Father	Sister	Brother	Other _____
	Indicate if Diagnosis was the Cause of Death and at what age.				
Alive and Well	☐____	☐____	☐____	☐____	☐____
Allergies	☐____	☐____	☐____	☐____	☐____
Asthma	☐____	☐____	☐____	☐____	☐____
Cancer, Type_____	☐____	☐____	☐____	☐____	☐____
COPD	☐____	☐____	☐____	☐____	☐____
Heart Disease	☐____	☐____	☐____	☐____	☐____
Diabetes	☐____	☐____	☐____	☐____	☐____
Hearing Loss	☐____	☐____	☐____	☐____	☐____
Bleeding Problems	☐____	☐____	☐____	☐____	☐____
Hypertension	☐____	☐____	☐____	☐____	☐____
Sickle Cell	☐____	☐____	☐____	☐____	☐____
Stroke	☐____	☐____	☐____	☐____	☐____
Sleep Apnea	☐____	☐____	☐____	☐____	☐____
Thyroid Problems	☐____	☐____	☐____	☐____	☐____
Other_____	☐____	☐____	☐____	☐____	☐____

Name: _____ Date of Birth: _____ Today's Date: _____

REVIEW OF SYSTEMS (Please Mark all that Apply)

Have you experienced any of the following recently:

General ☐Chills ☐Fever ☐Fatigue ☐Appetite change

☐Activity Changes ☐Sweating ☐Unexpected Weight Change

HEENT ☐Facial Swelling ☐Voice Changes

☐Ear Drainage ☐Nosebleeds ☐Drooling ☐Congestion ☐Mouth Sores

☐Runny Nose ☐Post Nasal Drip ☐Sneezing ☐Sinus Pressure

☐Dental Problems ☐Ringing in Ears ☐Difficulty Swallowing ☐Sore Throat

☐ Ear Pain ☐ Hearing Loss ☐ Sinus Pain ☐ Voice Change

Respiratory ☐Apnea ☐Choking ☐Shortness of Breath ☐Chest Tightness

☐Cough ☐Stridor ☐Wheezing

Gastrointestinal ☐Diarrhea ☐Constipation ☐Abdominal Bloating ☐Blood In Stool

☐Abdominal Pain ☐Anal Bleeding ☐Vomiting ☐Nausea ☐Rectal Pain

Endocrine ☐Cold Intolerance ☐Heat Intolerance ☐Excessive Thirst

☐Increase Hunger ☐Increase Urinary Frequency

Neurological ☐Dizziness ☐Facial Asymmetry ☐Headaches

☐Light-Headedness ☐Numbness ☐Seizure

☐Fainting ☐Tremor ☐Weakness ☐Speech Difficulty

Musculoskeletal ☐Joint Pain ☐Back Pain ☐Balance Problems ☐Neck Stiffness

☐Joint Swelling ☐Muscle Pain ☐Neck Pain

Psychiatric ☐Agitation ☐Depression ☐Hallucinations ☐Behavior Problem

☐Confusion ☐Decreased Concentration ☐Hyperactive ☐Nervous/Anxious

☐Self-Injury ☐Sleep Disturbance ☐Suicidal Ideas

Skin ☐Color Change ☐Unusual Paleness ☐Rash ☐Wound

Allergy/Immun ☐Environmental Allergies ☐Food Allergies ☐Immuno-Compromised

Smokeless Tobacco Use? ☐Never ☐Current ☐Former

Smoking? ☐Never ☐Current/Occ. ☐Previous Date Quit _____

Cigarette/pipe/cigar: _____ Packs per day: _____ Number of years: _____

Alcohol Use? ☐Yes ☐No Amount: _____ Frequency: _____