Dr. Todd Pearlstein, MD, Dr. Eric Law, MD, Dr. Melissa Behringer, MD
Phone: (334) 566-9800
Fax: (334) 566-3700

Name: _____
FIRST MIDDLE LAST

SSN: _____ **BIRTH DATE:** _____

MARITAL STATUS: Married_____ Single:_____ Divorced:_____ Widowed:_____

GENDER: Male Female Transgender Non-Binary/confirming Prefers not to answer

SEXUAL ORIENTATION: Heterosexual Bisexual Homosexual Pansexual Asexual Prefers Not to Answer

RACE: Asian Black Black or African American White

ETHNICITY: Central American Cuban Dominican Mexican Puerto Rican South American Spaniard

Hispanic or Latino/ Spanish Latin American/Latin, Latino Not Hispanic/Latino None

HOME PHONE: _____ **WORK PHONE:** _____ **CELLPHONE:** _____
Circle the phone number you want to be your primary contact phone number

PERMISSION TO TEXT CELLPHONE: YES:_____ NO:_____

EMAIL ADDRESS: _____

LOCAL PHARMACY: _____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name: _____ _____
FIRST LAST M.I TELEPHONE

SSN: _____ **BIRTH DATE:** _____

PHYSICAL ADDRESS: _____
STREET CITY STATE ZIP

MAILING ADDRESS: _____
STREET CITY STATE ZIP

EMPLOYER: _____ _____
NAME TELEPHONE

_____ _____
ADDRESS OCCUPATION

SOUTHERN HEALTH ASSOCIATES

FAMILY AND SPORTS MEDICINE

RESPONSIBLE PARTY:_____ _____
NAME RELATIONSHIP TELEPHONE

EMERGENCY CONTACT:_____ _____
SPOUSE/NEXT OF KIN NAME RELATIONSHIP TELEPHONE

PRIMARY INS:_____ _____
TELEPHONE

INSURED NAME:_____ **DOB:**_____ **GROUP #**_____ **POLICY #**_____

SECONDARY INS:_____ _____
TELEPHONE

INSURED NAME:_____ **DOB:**_____ **GROUP #**_____ **POLICY #**_____

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1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Southern Health Associates, LLC. I also authorize agents of any hospital, treatment center, or previous physicians to furnish Southern Health Associates, LLC. copies of any records of my medical history, services, or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research, and quality assurance reviews within Southern Health Associates, LLC.
3. My right to payment for all pharmaceuticals, procedures, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Southern Health Associates, LLC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Southern Health Associates, LLC.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) government bodies (such as the Food and Drug Administration; (c) representatives and agents of my health benefits plan; (d) persons conducting quality peer review or patient satisfaction surveys; and (e) other clinical and non-clinical parties that have a contractual relationship with Southern Health Associates, LLC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the form. A duplicate of the statement is considered the same as the original.

_____ _____
Patient Signature Date/time

_____ _____
Responsible Party Signature Relationship Date/time

EMPLOYEE INITIALS:_____

SOUTHERN HEALTH ASSOCIATES

FAMILY AND SPORTS MEDICINE

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy and Preventive Policy for SOUTHERN HEALTH ASSOCIATES
- I hereby assign my insurance benefits to be paid directly to the healthcare provider
- I authorize SOUTHERN HEALTH ASSOCIATES LLC to release medical information required to process my claim
- I have read and understand the Financial Policy for SOUTHERN HEALTH ASSOCIATES LLC
- I authorize SOUTHERN HEALTH ASSOCIATES LLC to obtain/have access to my medication history
- I authorize my provider's office to contact me by mobile phone

Signed: _____ Date: _____

Employee Signature:_____

SOUTHERN HEALTH ASSOCIATES

FAMILY AND SPORTS MEDICINE

PATIENT NAME:_____ **DATE OF BIRTH:**_____

MEDICAL HISTORY FORM

PRESENT HEALTH CONCERNS: _____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

ALLERGIES: _____

_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems:

___ Congenital Heart Disease
___ Myocardial Infarction (Heart Attack) – Date _____
___ Diabetes
___ High Cholesterol
___ Stroke
___ Thyroid Problem
___ Coagulation Disorder (Bleeding/Clotting)
___ Cancer _____ (Type)
___ Alcoholism
___ Blood Transfusion
___ Abnormal Pap Smear
___ Neurological Problems _____ (Type)

HEALTH MAINTENANCE: Please indicate date of testing

Pap Smear _____
PSA _____
DXA Bone Age _____
Pneumonia Vaccine _____
Shingles Vaccine _____
Colonoscopy _____
Mammogram _____
Flu Vaccine _____
Tetanus Vaccine _____

SURGICAL HISTORY: Please list all prior operations and dates

Operation	Date	Operation	Date

SOUTHERN HEALTH ASSOCIATES

FAMILY AND SPORTS MEDICINE

PATIENT NAME:_____ **DATE OF BIRTH:**_____

WOMEN'S GYNECOLOGICAL HISTORY:

Pregnancies_____
Deliveries _____
Abortions _____
Miscarriages _____
1st day of most recent period _____
Age of 1st period _____
Frequency of periods: _____
Length of bleeding _____
Any Concerns about your periods? _____

FAMILY HISTORY:

MEDICAL CONDITION	MOM	DAD	SISTER	BROTHER	DAUGHTER	SON	OTHER
Alcoholism							
Anemia							
Asthma							
Birth Defects							
Bleeding Problems							
Breast Cancer							
Colon Cancer							
Melanoma							
Ovarian Cancer							
Prostate Cancer							
Cancer, Other							
Depression							
Diabetes, Type 1 (child)							
Diabetes, Type 2 (adult)							
Eczema							
Epilepsy (Seizure)							
Genetic Disease							
Glaucoma							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Lupus							
Migraine Headache							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid Disorder							
Tuberculosis							
Other:							

SOUTHERN HEALTH ASSOCIATES

FAMILY AND SPORTS MEDICINE

PATIENT NAME:_____ **DATE OF BIRTH:**_____

SOCIAL HISTORY:

Tobacco Use:

Cigarettes

___ Current Smoker
___ Former Smoker: Quit Date _____
___ Never Smoked
___ Pipe Use
___ Cigar Use
___ Snuff Use
___ Chewing Tobacco

Are you interested in quitting? Y N

Alcohol Use:

___ No Alcohol Intake
___ # Drinks per week
___ Alcohol is a concern for others

Drug Use:

___ Recreational Drug Use
___ I have used needles

Do you exercise regularly? Y N

Occupation: _____ **Education Completed**: _____

MARITAL STATUS: Married Widowed Divorced Separated Single Cohabitating

Spouse/Partners Name: _____ Number of children: _____

Are you sexually active? _____ Current sex partners: ___ Male ___ Female ___Both

Birth Control method: _____ Have you been tested for STDs? Y N

Are you interested in being screened for STD's? Y N _____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interested or pleasure in things that you usually cared about or enjoyed? Yes or No
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? Yes or No
3. Have you felt depressed or sad much of the time in the past year? Yes or No

REVIEW OF SYSTEMS: Please check any current problems you have on the list below:

General:

___ Fever/Chills/Sweats
___ Unexplained wt change
___ Fatigue/Weakness
___ Excessive thirst/urination
___ Thyroid Problem

ENT:

___ Change In Vision
___ Difficult Hearing/ringing
___ Problems with teeth/gum
___ Muscle/joint pain

Chest:

___ Chest pain/discomfort
___ Leg pain with exercise
___ Palpitations

Other: _____

Respiratory:

___ Breast lump/discharge
___ Cough/wheeze
___ Difficulty Breathing

Gastrointestinal:

___ Blood in stool
___ Nausea/Vomiting/Diarrhea
___ Abdominal Pain

Genitourinary:

___ Leaking Urine
___ Unusual Vaginal Bleeding
___ Discharge: Penis or vagina
___ Sexual function problem
___ Nighttime Urination

Dermatology:

___ Rash
___ Change in mole
___ Numbness
___ Unexplained Lumps
___ Easy bruising

Neurology:

___ Loss of coordination
___ Headaches
___ Dizziness/Light-Headed
___ Memory Loss

Psych:

___ Problems with sleep
___ Depression
___ Anxiety/Stress

Southern Health Associates, LLC
P.O. Box 1185, Troy, AL 36081
Phone: (334) 566-9800 Fax: (334) 566-3700

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient(s) Name: _____ _____
First M. Last Date of Birth

( ) Release To **( ) Release From**

_____ _____ _____
Provider of Entity Provider Phone Number Provider Fax Number

_____
Address City State Zip Code

Information Requested
( ) Complete Medical Records
( ) Immunizations
( ) Other: _____

Purpose of Requested Use or Disclosure
( ) At the request of the individual
( ) Continued medical care
( ) Other: _____

I understand that the medical records, which I have authorized to be transferred, may contain information related to the diagnosis and/or treatment of a communicable or sexually transmitted disease designated by the State Board of Health (including but not limited to HIV). I authorize the release of all medical information concerning the diagnosis and/or treatment of this condition. **Initial One: Yes _____ No_____**

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be re-disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. I do not have to sign this authorization in order to receive treatment from Southern Health Associate, LLC. I have the right to revoke this authorization in writing except to the extent that Southern Health Associates, LLC has acted in reliance upon the authorization.

_____ _____ _____
Signature Printed Name Relationship to Patient

_____
Address City State Zip Code

_____ _____
Date of Authorization Witness Signature

This Authorization expires 90 days from Date of Authorization, or _____/_____/_____.