DR. IRFAN SYED
DR. AMBER SYED
3584 OLD MILTON PKWY
ALPHARETTA, GA 30005
PHONE: 678-691-3388
FAX: 678-395-7702
www.medassocga.com

PATIENT INFORMATION

NAME:_____ Email :_____
(first) (middle initial) (last)
Preferred Name:_____

ADDRESS: _____
(number and street) (apt #) (city) (state) (zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____ ok to leave msgs? YES NO
(cell or home) (cell or home)

BIRTH DATE: _____/_____/_____ SEX: □Female □Male MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ SS #: _____

ETHNICITY: □Hispanic or Latino □Non-Hispanic or Latino □Unknown □Declined

HOW DID YOU HEAR ABOUT US?: _____

Pharmacy Name & Address for Prescriptions to be sent to: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ ALTERNATE PHONE#: _____

HEALTH INSURANCE INFORMATION

***please be aware that MAG is not responsible for verification of in-network participation with your insurance carrier _____ (initial)**

_____ _____
PRIMARY INSURANCE NAME SECONDARY INSURANCE NAME

_____ _____
ID# ID#

_____ _____
GROUP# GROUP#

_____ _____
POLICY OWNER NAME & DOB (if not the patient) POLICY OWNER NAME & DOB (if not the patient)

I hereby authorize Medical Associates of Georgia to release medical information necessary for insurance reimbursement. I hereby authorize and assign payment directly to MAG for insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to MAG for all charges incurred regardless of potential insurance benefits. I understand it is my responsibility to understand my own insurance benefits and financial responsibilities in relation to my copay, coinsurances, deductibles and coverages.

X_____ X_____
Signed Date

2020 UPDATED OFFICE POLICIES

No Show policy: We strive to honor appointment times and respect patient's schedules. For this reason, patients who do not call to cancel or reschedule their appointments within 24 hours of their appointment time will be charged a $25 no show fee. Patients who do not call and cancel appointments or fail to show up repeatedly may be considered for dismissal from the practice. _____ (initial)

Rx Refills: Prescription refills are generally handled during your office visit by Dr. Syed himself. The office staff does not refill medications by phone. All prescriptions are electronically sent to your pharmacy by the close of the business day. All patients must have been seen within previous 3-4 months to obtain refills unless otherwise noted by Dr. Syed. _____ (initial)

Referrals: Please note that it may take up to 48 hours to obtain a referral to a specialist. In most cases, referrals can be given the same day. In the case of HMO policyholders, patients are responsible for obtaining referrals for specialist visits. Backdated referrals will not be processed so please be certain your referral has been approved by your insurance before making any specialist appointments. _____ (initial)

Lab Results: Lab results are usually available within 1 week depending on the type of testing being completed. The physician will require you to schedule an additional office visit to go over any significantly abnormal test results . These lab review visits are not part of routine physicals and may be subject to deductibles and copay/coninsurance _____ (initial)

Insurance and Billing: Patients are responsible for a co-payment, co-insurance and deductibles at the time of your visit. Deductibles are expected in full unless special arrangements are made. We do not want issues of payment to keep you from taking care of yourself and your health; we will make arrangements through our office which can be discussed at the time of your visit. Monthly statements on past due amounts are mailed monthly. _____ (initial)

Medical Records: Request for your medical records from our office requires your signature on a Medical Release form. Medical records are available with adequate notice. If you would like to request a copy of your records please complete the form while at our office or request the form to be faxed or emailed to you. There will be a charge depending on how many pages please call for rates. Charges for copying are in accordance with State provisions. There is no charge if your records are to be copied and sent to a physician or medical facility. _____ (initial)

By initialing above and signing below I am aknowleding that I have read and understand the office policies listed.

_____

Patient Signature

_____

Patient Name Print

_____

Date

_____

DOB

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DISCLOSURE OF HEALTH CARE INFORMATION NOTICE

I understand that as part of my healthcare, Medical Associates of Georgia, Inc. originates and maintains paper and/or electronic records describing my demographic information as well as records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information may serve as:

- ✓ A basis for planning my care and treatment.
- ✓ A means of communication among the many health professionals who may contribute to my care.
- ✓ Information for applying my diagnosis and surgical information.
- ✓ A means by which a third-party payer can verify that services billed were actually provided.
- ✓ A tool for routine healthcare operations such reviewing the competence of healthcare professionals and assisting quality.
- ✓ A means by which to contact me regarding my treatment, follow-up, and various test results.

I understand that I have the following rights and privileges:

- ✓ The right to review the "Notice of Information Practice" prior to signing this consent.
- ✓ The right to object to the use of my healthcare information for directory purposes.
- ✓ The right to request restrictions as to how my healthcare may be used or disclosed to carry out treatment, payment or healthcare operations.
- ✓ The right to revoke any prior consent, as provided in writing, except to the extent that the organization has already taken action.

I understand that Medical Associates of Georgia is not required to agree to the restrictions requested. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Medical Associates of Georgia reserves the right to change their notice of privacy practices. I will be notified of the changes in writing, upon my next visit.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

In the event Medical Associates of Georgia refers me to a SPECIALIST, I hereby authorize Medical Associates of Georgia to release my medical records to the SPECIALIST and also to authorize the SPECIALIST to release my medical records and SPECIALIST REPORTS back to Medical Associates of Georgia.

I wish to implement the following limitations or allowances regarding the use or disclosure of my healthcare information:

_____

_____

I fully understand and ❑ ACCEPT ❑ DECLINE the terms of this consent. (Please check one)

_____ _____

Patient or Guardian Signature Date

FOR OFFICE USE ONLY:

- ❑ Consent received by:_____
- ❑ Consent refused by patient, and treatment refused as permitted
- ❑ Consent added to the patient's medical record on _____

New Patient Medical History - Please complete this form prior to your first appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Current Medical History ♦

Condition / Disease	*Year Diagnosed*	*Condition / Disease*	*Year Diagnosed*
❑ Hypertension		**other Medical Conditions:**	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below all other physicians/specialties seen within past year (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medications	*Reaction*	*Foods/Environmental*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

additional space available on next page

♦ Social, Educational and Work History (optional) ♦

Marital Status:	
Work Status (circle one): Employed / Unemployed / Retired / Disabled	Current or Prior Occupation:
Highest Level of Education:	Do you drink alcohol?
How often do you drink? ❑ Monthly or less ❑ 2-4 times a month ❑ 2-4 times a week ❑ 4 or more times a week	
No. of drinks typically in one sitting:	
Are you a current smoker? Yes / No Are you a former smoker? Yes / No What year did you quit?	
If you smoke, how many packs per day?	No. of years you smoked?
Have you ever attempted to quit smoking or do you want to quit now? Yes / No	

♦ Sexual History (optional) ♦

Are you sexually active: Yes / No	Sexual Orientation:
How many partners have you had during the past 12 months? _____	Birth Control Methods Used: ❑ None ❑ Condoms ❑ Birth Control Pill ❑ IUD ❑ Other: _____
Have you ever been treated for any STD's? Yes / No	

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Major Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Other:				

♦ Disease Prevention and Diagnostic Testing ♦

Please list below the latest year of your vaccines and other tests if applicable

Vaccine /Lab testing	***Year***	***Diagnostic Test***	***Year***	***Normal/Abnormal Result***
Pneumonia		EKG		
Shingles		Pap Smear		
HIV screening		Mammogram		
Hep C screening		Colonoscopy		
Eye Exam		Bone Density		

Feel free to use this space for additional medications, allergies or other medical history if needed: