TREKEN PRIMARY CARE, INC

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosure of my protected health information that may be made by this practice, my individual rights and the practice's duties with respect to my protected health information. The Notice includes:

- A statement this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of other uses and disclosures that are prohibited or materially limited by law
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

    1. The rights to complain to this practice and the Secretary of Human Health Services if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint
    2. The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction
    3. The right to received confidential communications of protected health information
    4. The right to inspect and copy protected health information
    5. The right to amend protected health information
    6. The right to receive an accounting of disclosures of protected health information
    7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of the patient): _____

TREKEN PRIMARY CARE, INC

Account No: _____ Date: _____

PERSONAL DEMOGRAPHICS

Patient Name: _____ Birthdate: _____
Address: _____

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Social Security #: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Email address: _____
Person responsible for charges (if other than patient): _____
Address: _____
Relationship to patient: _____ last 4 of SS#_____
Home Phone: _____ Work Phone: _____

Preferred Contact/Follow up Method: Phone ☐ Email ☐ Text ☐

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____
Address: _____
Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name: _____
Insurance Company: _____
Address: _____
Phone: _____
Effective Date: _____
ID/Contract #: _____
Group/Plan#: _____

Secondary Insurance

Policy Holder Name: _____
Insurance Company: _____
Address: _____
Phone: _____
Effective Date: _____
ID/Contract #: _____
Group/Plan#: _____

I authorize treatment for the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits directly to Treken Primary Care, Inc.
I authorize the release of correspondence and/or medical records to other medical providers involved in my care.
I have read and understand the financial policy.

Signature: _____ Date: _____

TREKEN PRIMARY CARE, INC

777 Cleveland Avenue · Suite 604·
Atlanta, GA 30344
Phone: (404) 305-0004 Fax: (404) 305-0494

HEALTH QUESTIONNAIRE

REASON FOR VISIT

FAMILY HISTORY — *IF ANY RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE*

1) Epilepsy	11) Bleeds easily	
2) Migraines	12) Osteoporosis	
3) Mental Illness	13) Arthritis	
4) Glaucoma	14) Heart disease	
5) Diabetes	15) Stroke	
6) Thyroid Disease	16) High blood pressure	
7) Hayfever	17) High cholesterol	
8) Asthma	18) Alcoholism	
9) Anemia	19) Hepatitis	
10) Cancer	20) Others, please specify:	

HOSPITAL ADMISSIONS (Not including pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING (include those you buy without prescriptions)	ALLERGIES	VACCINES	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
		Tetanus/Td	_____	Colonoscopy	_____
		Influenza (flu)	_____	RectalExam/PSA	_____
		Pneumonia	_____	Mammogram	_____
		Hepatitis	_____	TB test	_____
		Shingles	_____	Pap smear	_____
		HPV	_____	Bone density	_____

MEDICAL HISTORY — *MARK (C) FOR CURRENT PROBLEMS. CHECK (☑) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

❒Heart murmur
❒Swollen ankles
❒Irregular pulse
❒Palpitations
❒Shortness of breath
❒On exertion
❒Lying flat
❒Leg pain: when walking
❒Mental illness
❒German measles
❒Loss of appetite: (recent)
❒Difficulty swallowing
❒Heartburn
❒Peptic ulcer
❒Nausea/Vomiting

❒Abdominal pain
❒Gallbladder trouble
❒Jaundice/hepatitis
❒Seizures
❒Stroke
❒Diarrhea
❒Constipation
❒Diverticulosis
❒Crohn's/Ulcerative colitis
❒IBS
❒Bloody or tarry stools
❒Hemorrhoids
❒Hernia
❒Urination: Incontinence
❒Urination: Blood

❒Tremor/hand shaking
❒Headaches
❒Numbness
❒Arthritis/rheumatism
❒Bone fracture/joint injury
❒Osteoporosis
❒Back pain
❒Gout
❒Foot pain
❒Rashes
❒Kidney stones
❒Urine infections: frequent
❒Weight loss/gain
❒Height loss
❒Appetite

❒Anemia
❒Bruise easily
❒Blood transfusions
❒Cancer
❒Easily fatigued
❒Diabetes
❒Hives
❒Psoriasis
❒Eczema
❒Sexual problems
❒Depression
❒Nervousness
❒Memory Loss
❒Rheumatic fever
❒Scarlet fever

❒Chicken pox
❒Measles
❒Herpes
❒Polio
❒Mumps
❒Tuberculosis
❒AIDS/HIV
❒STDs
❒Sleep problems:
How long:_____
How frequent:_____
❒Alcohol _____ oz/week
❒Coffee/tea _____ cups/day
❒Smoking: _____ cig/day
How many years? _____
Year quit:

❒Hair loss: recent
❒Hair loss: progressive
❒Male: prostate problems
❒Female: BC pill
❒Flushing, menopause
❒Fevers
❒Chills
❒Nightsweats
❒Swollen glands
❒Joint aches
❒Muscle aches
❒Urinary frequency
❒Frequent thirst
❒Chest pain
❒Cough