

NEW IMAGE

Medical Aesthetics & Wellness

Patient Information Form

Last Name _____
First Name _____ M.I. ____
Street Address _____ _____
City _____ State _____
Zip _____
Home Phone _____
Cell/Pager _____
Birthdate ____ / ____ / ____
Social Sec. # ____ - ____ - ____
Employer _____
Employer's Phone _____
Are you: Single Married Divorced Widowed
Emergency Contact _____
Emergency Contact Phone _____

Who referred you _____

INSURANCE INFORMATION

Medicaid # _____

Medicare # _____

Primary Insurance _____

Primary Policy # _____

Primary Group # _____

Secondary Insurance _____

Secondary Policy # _____

Secondary Group # _____

Responsible Party (if different from above):

Address _____

City _____ *State* _____ *Zip* _____

Social Security # ____ - ____ - ____

Birth Date ____ / ____ / ____

I authorize Georgia Women's Care, P.C. to bill my insurance company for charges incurred during the course of my treatment and to provide any medical information necessary to process this claim. I authorize payment to be made directly to Georgia Women's Care, P.C. A copy of this authorization may be used instead of the original. I authorize Georgia Women's Care, P.C. to inquire about my accounts and to receive any information about any and all of Medicare, Medicaid, Blue Cross, or other insurance claims, assigned or non-assigned, and I understand that I am fully responsible for charges incurred with my treatment including charges that may not be covered by my insurance. Payment of charges is expected at the time of service for self-pay patients or immediately upon receipt of any bills sent by mail. Copayments must be paid at the time of check-in for an appointment. I understand that delinquent accounts over 60 days may be sent to a collection agency. Normally, we will share information from your visit with your referring physician and leave normal results on your answering machine or voice mail. Please let us know if you do not wish us to do either of these services.

Signature

Date

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Privacy Policy and Consent to Treatment

Please note that all Registered Nurses, Nurse Practitioners, and Physicians who provide medical services New Image Medical Aesthetic Center are employees of Georgia Women's Care, PC. Georgia Women's Care, PC is the medical practice of Gregory P. Zengo, MD. New Image Medical Aesthetic Center does not provide medical services directly to patients.

By signing this form, you are granting consent to New Image Medical Aesthetic Center and the providers employed by Georgia Women's Care, P.C. to provide you medical services reasonable within today's standards of care. You also consent for us to use and disclose your protected health information for the purposes of treatment, payment and health care operations.

We value your privacy and want you to be assured that your confidential medical information will be used by our physicians and staff for the purposes of delivering medical care to you. Our paper records are kept in a locked office. Our electronic records are protected by two layers of passwords and are not accessible over the Internet or by a dial-up connection from outside the office. Occasionally some of your medical information may be accessible to other people. For example, in an effort to communicate appointment confirmations we may leave messages on your answering machine. We may also leave messages with some test results (usually they will say that your results were normal or that you need to call us back), or send you correspondence in the mail. Sometimes bills we send you may contain information about your visits in code form. Additionally, we must share your medical diagnoses with your insurance company in order to receive payment for our services. Unless you object, we may share some of your medical information with your referring physician, or send information on to a physician we may refer you to. Otherwise, if another person requests your medical information without a signed release from you, we will not share your medical information with them unless we are legally bound to do so.

As part of your treatment, you also consent to any laboratory testing that we deem essential to the delivery of your care.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to refuse any test or procedure that we deem medically necessary and assume any risks that the absence of this treatment or testing may have on your health.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

(if patient is under 18 and not pregnant)

NEW IMAGE

Medical Aesthetic Center

Gregory P. Zengo, MD

Gynecology & Integrative Medicine

Name _____

Today's Date ____/____/____

NEW PATIENT HISTORY FORM

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

LIST ANY OTHER PHYSICIANS YOU SEE *(Last OB/GYN for women only)*

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN
	OB/GYN		

WHY ARE YOU SEEING US TODAY? _____

MEDICAL HISTORY *Have you or members of your family had any of the following:*

CONDITION	YOU	FAMILY
High Cholesterol		
Heart Disease/Attack		
Rheumatic Fever		
High Blood Pressure		
Stroke		
Blood Clots		
Asthma		
Tuberculosis		
Diabetes		
Thyroid Problems		
Liver Disease		
Hepatitis		
Gallstones		

CONDITION	YOU	FAMILY
Arthritis		
HIV/AIDS		
Kidney/Bladder Problem		
Anemia		
Blood Transfusion		
Bleeding Disorder		
Breast Disease		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Birth Defects		
Genetic/Inherited		

OTHER MEDICAL HISTORY _____

PREVIOUS SURGERIES (Include C-Sections and Tubal Ligations)

YEAR	OPERATION	HOSPITAL	COMMENTS

CURRENT PRESCRIPTION MEDICATIONS

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

CURRENT NON-PRESCRIPTION MEDICINES (Include Herbals and Supplements)

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

MEDICATION ALLERGIES

	NAME	REACTION	

HORMONE BALANCE QUESTIONS – MEN ONLY (Women Please Turn the Page...)

- Men, please **check** all symptoms you currently have.
- Place a **star** next to symptoms that are **new** in the past year.

HOT FLASHES	EXCESSIVE SWEATING	PREMATURE EJAC.
ERECTILE DYSFUNCTION	FEWER MORNING ERECTIONS	POOR SEX DRIVE
DECREASED MUSCLE MASS	LACK OF INITIATIVE	AGGRESSIVENESS
SLOWER BEARD GROWTH		

Have you ever had a PSA (Prostate Specific Antigen) Blood Test? ____ YES ____ NO

HORMONE BALANCE/GYN QUESTIONS – WOMEN ONLY

- Women, please **check** all symptoms you currently have.
- Place a **star** next to symptoms that are **new** in the past year.

HEAVY PERIODS	PAINFUL PERIODS	CYCLIC HEADACHES
BLEEDING BETWEEN PERIODS	PERIODS START EARLY	CYCLIC BLOATING
CYCLIC MOODINESS	BREAST TENDERNESS	LOW SEX DRIVE
CRYING SPELLS	VAGINAL DISCHARGE/ITCHING	VAGINAL DRYNESS
PAINFUL INTERCOURSE	HOT FLASHES/NIGHT SWEATS	BLEEDING AFTER SEX
PAINFUL URINATION	LOSS OF BREAST MASS	BREAST LUMPS
NIPPLE DISCHARGE	ABNORMAL MAMMOGRAM	ABNORMAL PAP

Have you ever had... HERPES GENITAL WARTS CHLAMYDIA GONORRHEA SYPHILIS

What do you currently use for Birth Control? _____

Have you had more than one sexual partner in the past year? ___ YES ___ NO

At what age did you first have periods? ___ *When was the first day of your last period?* _____

When was your last pap smear? _____ *When was your last mammogram?* _____

Do you do breast self-examination _____ MONTHLY _____ SOMETIMES _____ NEVER

How many DELIVERIES _____ *and MISCARRIAGES* _____ *have you had?*

GENERAL SYMPTOM QUESTIONS – BOTH MEN AND WOMEN

- Please **check** all symptoms you currently have.
- Place a **star** next to symptoms that are **new** in the past year.

MORNING FATIGUE	AFTER LUNCH FATIGUE	EVENING FATIGUE
“SECOND WIND” AFTER SUPPER	CAN'T TURN MY MIND OFF AT BEDTIME	
CARB/SWEET CRAVINGS	SALT CRAVINGS	CHOCOLATE CRAVINGS
FORGETFUL	FOGGY THINKING	LESS ORGANIZED
SLOWER MIND	LESS PRODUCTIVE	IRRITABLE
SHORT-TEMPERED	ABDOMEN WEIGHT GAIN	DIETS DON'T WORK
NO ENERGY	SKIN CHANGES	“NERVOUS STOMACH”
COLD BODY TEMPERATURE	HAIR LOSS	PUFFY FACE
MUSCLE/JOINT ACHES	CHRONIC INFECTIONS	

LIFESTYLE QUESTIONS

Do you smoke cigarettes? ____ YES ____ NO If so, how many cigarettes per day? _____

Do you drink alcohol? ____ YES ____ NO If so, how many drinks per week? _____

Do you use any street drugs? ____ YES ____ NO (*all answers are confidential*)

How many caffeine-containing drinks do you have a day? _____ (*coffee, tea, sodas, energy drinks*)

What time do you go to bed at night? _____ How long until you fall asleep? _____

How many times do you wake up a night? _____ Do you go to sleep with the TV on? _____

What do you do when you wake up at night? _____

What time do you wake up in the morning on a typical work day? _____

Do you take anything to help you fall asleep? _____

Do you eat after 8PM? ____ YES ____ NO Do you feel refreshed when you wake up? _____

Do you exercise for at least 30 minutes at a time, at least 3 days per week? ____ YES ____ NO

What do you do for exercise? _____

What time of day do you usually exercise? _____

How many meals a day do you eat? ____ Do you snack between meals? ____ YES ____ NO

Do you drink at least 64 ounces of water per day? ____ YES ____ NO

What prescription diet pills have you taken in the past? _____

What was your most successful diet? _____ How much did you lose? _____

How much weight would you realistically like to lose in the next year? _____ pounds.

STRESS QUESTIONS

- Please **check** all events that currently impact your life.
- Place a **star** next to events that are **new** in the past year.

MOVED YOUR HOME

JOB CHANGE

JOB STRESS/LOSS

ILL FAMILY MEMBERS

MARITAL PROBLEMS

DIVORCE/SEPARATION

DEATH OF SPOUSE/CHILD

FORECLOSURE/BANKRUPTCY

LEGAL PROBLEMS

NEW MARRIAGE

RETIREMENT

TROUBLE W/ IN-LAWS

PROBLEMS WITH CHILDREN

NEW PERSON LIVING WITH YOU

THANK YOU. THIS CONCLUDES OUR QUESTIONNAIRE

Georgia Women's Care, P.C.

NEW IMAGE

Medical Aesthetics & Wellness

2 South Main Street, Suite 206
Watkinsville, 30677
Phone-(706)769-5757
Fax- (706)769-5780

Gregory P. Zengo, MD

To Whom It May Concern:

I hereby authorize the release of my medical records to:

Georgia Women's Care, P.C.
2 South Main Street, Suite 206
Watkinsville, GA 30677
Phone-706-769-5757
Fax-706-769-5780

Name _____

Birthdate _____

Social Security Number _____

Patient Signature _____

Witness _____

Date _____

Thank You