# ANNISTON MEDICAL CLINIC
## PATIENT INFORMATION

If you are a new patient, please complete all of the information requested below. If you are already a patient of the Anniston Medical Clinic, please provide information below only for those items that have changed since you last completed this form.

### Patient Information:

Today's Date: _____

Please list your full name: _____
First Middle Maiden Last Suffix

Patient's Birthdate: _____ Patient's Social Security#: _____

Sex: M / F Race: ☐ African American ☐ White ☐ Latino ☐ Asian ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Latino ☐ Asian ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Were you referred by another doctor? _____ Which doctor referred you? _____

If not referred by another doctor, how did you learn about the Anniston Medical Clinic and your requested doctor here? _____

Please list your mailing address:

_____
Apt # Street # Street P.O. Box City State Zip Code

Email: _____ Home Telephone#: _____

Are you employed full-time: _____ Work Telephone #: _____

Please list your primary employer: Cell Phone#: _____

_____
Employer Name Street or P.O. Box City State Zip Code

### Emergency Contacts:

_____
Name Relationship to Patient Phone

_____
Name Relationship to Patient Phone

_____
Name Relationship to Patient Phone

## Guarantor Information:

If someone other than the patient will be responsible for payment of the patient's medical bills, then the guarantor information requested below must be completed and signed by the responsible person.

Please list your full name: _____
First Middle Maiden Last Suffix

Date of birth: _____ Social Security #: _____

Please list your street address (no post office boxes, please):

_____
Apt # Street # Street P.O. Box City State Zip Code

Email: _____ Home Telephone #: _____

Are you employed full-time: _____ Work Telephone#: _____

Please list your primary employer: Cell Phone #: _____

_____
Employer Name Street or P.O. Box City State Zip Code

## Insurance Information:

We will need to make a photocopy of all of your currently effective insurance cards - be sure to bring these with you at the time of your visit and present them to the receptionist. Please list the names of all insurance coverages currently in effect which will be used to pay patient's medical bills (list your primary insurance first).

Primary Insurance (we will file first to this insurance):

_____
Insurance Name Insured Person Policy # Group #

_____
Cardholders Name Cardholders Date of Birth

Other Insurance (we will file amounts not paid by primary insurance to these insurances):

_____
Insurance Name Insured Person Cardholders Date of Birth Policy # Group #

_____
Insurance Name Insured Person Cardholders Date of Birth Policy # Group #

## NOTICE TO PATIENT AND GUARANTOR

Please read the following statements carefully and sign and date in the spaces provided. All medical services rendered are charged to the person responsible for the patient's account, as identified above. Our business office staff will file insurance claims for you to the above identified insurances unless you indicate below that you wish to file your own insurance claims. The Anniston Medical Clinic participates in the Medicare and Blue Cross PMD programs and, as such, are required to file your claims directly with these insurers. The patient and the patient's guarantor are responsible for payment to the Anniston Medical Clinic any amounts billed but not paid by insurance no later than 90 days after the date of service. Unless otherwise provided in your insurer's contract with the Anniston Medical Clinic, we expect payment for all services provided at the time they are rendered, unless alternative payment arrangements have been made with our Patient Financial Counselor. By signing below, the patient authorizes representatives of the Anniston Medical Clinic, P.C. to release any medical records pertinent to the patient's care by doctors of the clinic to insurance carriers identified by the patient or guarantor for the purpose of evaluation of eligibility for insurance coverage and payment of medical services rendered. Patient and guarantor agree to assign to the Anniston Medical Clinic P.C. all payments made by insurance carriers for services rendered to patient by Anniston Medical Clinic doctors and staff.

I have read the above Notice to Patient and Guarantor and **I agree** to be bound by its provision:

_____ _____
Patient Signature Guarantor Signature (if not patient)

_____ _____
Date Date

**ANNISTON MEDICAL CLINIC, P.C.**
1010 CHRISTINE AVENUE
P.O. BOX 2127
ANNISTON, ALABAMA 36202
(256) 236-5631

# Policy 7

## CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. Under this Law, we have the right to refuse to treat you should you choose to refuse to sign this consent. Some ways we may communicate with you are including but not limited to: leaving messages on your home phone, to family members or others answering the phone, to family members or others answering your phone.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request in writing that The Practice restrict how PHI is used or disclosed to carry out treatment, payment or health care operations. The Practice is not required to agree to requested restrictions, however; if The Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

In addition to the individuals listed in the Privacy Practices Guidelines, you may also communicate with the following individuals regarding my condition or course of treatment:

_____

You may communicate confidential information to me, including invoices for services, to the address and/or phone numbers already listed with the clinic. Any others you may communicate to will be listed below:

_____

_____ _____

Patient Signature or Personal Representative Date

As personal representative, I have authority to act for the individual because I am the individual's -

_____

#190 AMC BUSBY PRINTING 256/835-5679

# Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
**Please review it carefully.**

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We will say "yes" to all reasonable requests. |

*continued on next page*

## Your Rights *continued*

**Ask us to limit what we use or share**

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | • Share information with your family, close friends, or others involved in your care<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>• Contact you for fundraising efforts<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | • Marketing purposes<br>• Sale of your information<br>• Most sharing of psychotherapy notes |
| **In the case of fundraising:** | • We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | • We can use your health information and share it with other professionals who are treating you. | ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | • We can use and share your health information to run our practice, improve your care, and contact you when necessary. | ***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | • We can use and share your health information to bill and get payment from health plans or other entities. | ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as:<br>  • Preventing disease<br>  • Helping with product recalls<br>  • Reporting adverse reactions to medications<br>  • Reporting suspected abuse, neglect, or domestic violence<br>  • Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | • We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>  • For workers' compensation claims<br>  • For law enforcement purposes or with a law enforcement official<br>  • With health oversight agencies for activities authorized by law<br>  • For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**

# ANNISTON MEDICAL CLINIC, P.C.

**1010 Christine Avenue**
**P.O. Box 2127**
**Anniston, Alabama 36202**
**(256) 236-5631**


## Acknowledgement of Receipt

**ELECTRONIC PRESCRIBING (ePrescribing) and MEDICATION HISTORY**

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These are:

- **Formulary and Benefit Transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication History Transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill Status Notification** - Allows the prescriber to receive an electronic notice from the pharmacy to let them know the medication has been filled successfully and is ready for patient pickup.

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By signing this consent form you are agreeing that Anniston Medical Clinic, P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I also understand that Anniston Medical Clinic utilizes healthcare technology and participates with SureScripts™. SureScripts™ operates the Pharmacy Health information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts™ also facilitates notifying providers of any medications prescribed to me (medication history).

Patient Name (Please Print) : _____

Date of Birth: _____

_____ _____

Patient Signature

Parent or Legal Representative
(If Patient is under 19)

_____

Date

**Review of Systems: Please check if you have had any of the following symptoms, diseases, or findings:**

**GENERAL/ENDOCRINE:**
- ☐ Weakness, lethargy
- ☐ Chills or night sweats
- ☐ Frequent voiding, urinating at night
- ☐ Other:_____

**PSYCHIATRIC:**
- ☐ Depression, cry often, or feel sad
- ☐ Hear voices
- ☐ Nervous breakdown
- ☐ Other:_____

**HEAD:**
- ☐ Frequent headaches]
- ☐ Dizzy spells
- ☐ Earache or ear drainage
- ☐ Other:_____

**EYES:**
- ☐ Wear glasses/ contacts (circle one)
- ☐ Wear glasses only to read
- ☐ Eye pains or itching
- ☐ Other:_____

**EARS:**
- ☐ Deafness, decreased hearing
- ☐ Earaches or drainage
- ☐ Noise or ringing in ears
- ☐ Other:_____

**NOSE:**
- ☐ Congestion / sneezing
- ☐ Sinus trouble / hay fever
- ☐ Nose bleeds, date of last_____/_____
- ☐ Other:_____

**MOUTH/THROAT/NECK:**
- ☐ Sores in mouth
- ☐ Dental problems
- ☐ Goiter / thyroid problems
- ☐ Other:_____

**INFECTIONS (now or in the past):**
- ☐ Rheumatic Fever, age:_____
- ☐ Nephritis, Bright's Disease
- ☐ Measles, age:_____
- ☐ Mumps, age:_____
- ☐ Chicken Pox, age:_____
- ☐ Polio, age:_____
- ☐ AIDS (or tested HIV positive)
  If so, date diagnosed:_____/_____
- ☐ Other:_____

**GASTROINTESTINAL:**
- ☐ Heartburn or indigestion
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Recent change in bowel habits
- ☐ Other:_____

**CARDIOVASCULAR/HEART:**
- ☐ Chest pain and tightness at rest
- ☐ Swelling of feet
- ☐ Dizzy or woozy when standing
- ☐ Palpitations (skipped beats)
- ☐ Sleep on pillows or in chair due to shortness of breath
- ☐ Other:_____

**RESPIRATORY/LUNG:**
- ☐ Cough, productive of sputum
  If so, color of sputum:_____
- ☐ Cough, not productive of sputum
- ☐ Snoring
- ☐ Wheezing / Asthma
- ☐ Other:_____

**MUSCULOSKELETAL:**
- ☐ Gout
- ☐ Arthritis, degenerative
- ☐ Arthritis, rheumatoid
- ☐ Aching muscles / joints
- ☐ Other:_____

**HEMATOLOGY/LYMPHATIC:**
- ☐ Bleed or bruise easily
- ☐ Anemia / low blood
- ☐ Cancer, what kind:_____
- ☐ Other:_____

**NEUROLOGICAL:**
- ☐ Convulsions / seizures
- ☐ Stroke / paralysis
- ☐ Memory problems
- ☐ Other:_____

**GENITOURINARY:**
- ☐ Frequent voiding, urinating
- ☐ Difficulty starting urination
- ☐ Other kidney diseases
- ☐ Other:_____

**MEN ONLY:**
- ☐ Weak urine stream
- ☐ Prostate trouble or infection
- ☐ Problem with sexual intercourse
- ☐ Other:_____

**WOMEN ONLY:**
- ☐ Date last pap smear:_____
- ☐ Number pregnancies:_____
- ☐ Number miscarriages:_____
- ☐ Date last period (menses):_____
- ☐ Menstrual problems
- ☐ Date last mammogram:_____
- ☐ Other:_____

I personally reviewed and confirmed the information on this form.

_____ Patient Name _____

MD Signature Medical Record # _____

# Adult Medical History Form

Please complete All **3** PAGES

Name _____

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

**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 or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:**

| Medication | Reaction or Side Effect |
|---|---|
| | |
| | |

## PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

____Congenital Heart disease:
*specify type*
_____
____Myocardial Infarction (Heart attack)
____Hypertension (High blood pressure)
____Diabetes
____High cholesterol____
____Stroke ____
____Thyroid problem
*specify type*_____

____Coagulation (bleeding/clotting) disorder
____Cancer (Malignancy)
*specify type*_____
____Depression/suicide attempt
____Alcoholism
____If you have ever had a blood transfusion, please specify date
_____Abnormal Pap smear

Other problems
_____
_____
_____

When was your last Tetanus shot?
_____

**SURGICAL HISTORY:** (Please list all prior operations and dates):

| Operation | Date |
|---|---|
| | |
| | |

| Operation | Date |
|---|---|
| | |
| | |

## WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies:____ # deliveries:____ # abortions:____ # miscarriages:____
1st day, most recent period:_____ Age at 1st period: ____ Frequency of periods: _____ Length of each:_____
Do you have any concerns about your periods? ☐ No ☐ Yes: _____
Do you have any concerns about menopause? ☐ No ☐ Yes: _____

## FAMILY HISTORY:

Please indicate with a check (√) family members who have had any of the following conditions:

| Medical Condition | Mom | Dad | Sist. | Bro. | Daug. | Son | Other close relatives |
|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | |
| Anemia | | | | | | | |
| Anesthesia problem | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Birth Defects | | | | | | | |
| Bleeding problem | | | | | | | |
| Cancer, Breast | | | | | | | |
| Cancer, Colon | | | | | | | |
| Cancer, Melanoma | | | | | | | |
| Cancer, skin (except melanoma) | | | | | | | |
| Cancer, Ovary | | | | | | | |
| Cancer, Prostate | | | | | | | |
| Cancer (not noted) | | | | | | | |
| Depression | | | | | | | |
| Diabetes, Type 1 (childhood onset) | | | | | | | |
| Diabetes, Type 2 (adult onset) | | | | | | | |
| Eczema | | | | | | | |
| Epilepsy(seizures) | | | | | | | |

| Medical Condition | Mom | Dad | Sist. | Bro. | Daug. | Son | Other close relatives |
|---|---|---|---|---|---|---|---|
| Genetic diseases | | | | | | | |
| Glaucoma | | | | | | | |
| Hay fever (Allergic Rhinitis) | | | | | | | |
| Hearing problems | | | | | | | |
| Heart Attack (Coronary Artery Disease) | | | | | | | |
| High Blood Pressure (Hypertension) | | | | | | | |
| High cholesterol (Hyperlipidemia) | | | | | | | |
| Kidney diseases | | | | | | | |
| Lupus (Systemic Lupus Erythematosis) | | | | | | | |
| Mental retardation | | | | | | | |
| Migraine headaches | | | | | | | |
| Mitral Valve Prolapse | | | | | | | |
| Osteoarthritis | | | | | | | |
| Osteoporosis | | | | | | | |
| Rheumatoid Arthritis | | | | | | | |
| Stroke | | | | | | | |
| Thyroid disorders | | | | | | | |
| Tuberculosis | | | | | | | |
| Other: | | | | | | | |

## SOCIAL HISTORY:

**SUBSTANCES**

**Tobacco Use**

Cigarettes

Quit: Date_____

Never

☐ Current: Smoker: packs/day____ # of yrs _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ No ☐ Yes

**Alcohol Use**

Do you drink alcohol? ☐ No ☐ Yes: # drinks/week_____
Is alcohol use a concern for you or others? ☐ No ☐ Yes

**Drug Use**

Do you use any recreational drugs? ☐ No ☐ Yes
Have you ever used needles? ☐ No ☐ Yes

**EXERCISE:**

Do you exercise regularly? ☐ No ☐ Yes

**SOCIOECONOMICS:**

Occupation:_____

Education completed: ☐ Grade school ☐ High school
☐ College ☐ Graduate school
Years of education _____

Marital status: ☐Single ☐M ☐Sep ☐D ☐W ☐Co-habiting
☐Engaged...☐Other:_____

Spouse/Partner's name:_____
Number of children:_____
Who lives at home with you?_____

**SEXUALITY**

**Sexual Activity**

Sexually Active: ☐ Yes ☐ No ☐ Not currently
Current sex partner(s) is/are: ☐ male ☐ female

**Contraception and Protection**

Birth Control method:_____ ☐ None needed
If sexually active, do you practice safe sex? ☐ NA ☐ No ☐ Yes
Have you ever had any sexually transmitted diseases (STDs)?
☐ No ☐ Yes
If yes, please include:
_____ date_____
_____ date_____

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

Other concerns?_____

_____

**SAFETY:**

Do use seatbelts consistently? ☐ No ☐ Yes
Do you use a bike helmet regularly? ☐ NA ☐ No ☐ Yes
Is violence at home a concern for you? ☐ No ☐ Yes
Do you feel safe in your current relationship? ☐ NA ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes

Other concerns?_____

_____

**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 interest or pleasure in things that you usually cared about or enjoyed? ☐ No ☐ Yes
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? ☐ No ☐ Yes
3. Have you felt depressed or sad much of he time in the past year? ☐ No ☐ Yes

**IMMUNIZATIONS:**

Please list your most recent immunizations. You do NOT need to include any immunizations given at Harvard Vanguard Medical Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A____
Hepatitis B____
Tetanus (Td)____
Measles____Mumps____Rubella____
MMR____
Varicella (chicken pox) shot____
Pneumovax (Pneumonia)____
Other_____

**REVIEW OF SYSTEMS:** Please check (√) any current problems you have on the list below.

*Constitutional*
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination
*Eyes*
___Change in vision
*Ears/Nose/Throat/Mouth*
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies
*Cardiovascular*
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations
*Chest (breast)*
___Breast lump/discharge
*Respiratory*
___Cough/wheeze
___Difficulty breathing
*Gastrointestinal*
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea
*Genitourinary*
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
*Musculo-skeletal*
___Muscle/joint pain
*Skin*
___ Rash or mole change
*Neurological*
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination
*Psychiatric*
___Anxiety/stress
___Problems with sleep
___Depression
*Blood/Lymphatic*
___Unexplained lumps
___Easy bruising/bleeding
*Other (please specify)* _____
_____

## ANNISTON MEDICAL CLINIC
## PATIENT PORTAL SIGN UP FORM

☐ YES I WOULD LIKE TO SIGN UP FOR THE PATIENT PORTAL (PLEASE READ AND FILL OUT THE FORM BELOW)

☐ NO I WOULD NOT LIKE TO SIGN UP FOR THE PATIENT PORTAL AT THIS TIME (PLEASE SIGN BELOW AND DATE)

**PLEASE USE THE FORM BELOW TO SIGN UP FOR OUR PATIENT PORTAL.**

Patient Name (First & Last): _____

Patient Birth Date: _____

Phone Number: _____

Email Address: _____

The patient portal is designed to enhance secure patient-physician communications and is provided as a courtesy to our valued patients. This secure portal uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

**Via the Patient Portal you will be able to:**

- Use the message function to communicate with our staff
- Communicate results from staff of laboratory and diagnostic results
- View medication list and request refills on those prescribed by our office
- View and print health summary
- View demographic/insurance information and sent staff requests to update information
- View upcoming scheduled appointments

We will respond to portal inquiries within 1 business day. The patient portal is **not** intended for emergency communications or services. If you have an emergency please go to the nearest phone and call 911 or go to your nearest emergency room.

Please fill out this form and return it to the front desk. Once this is complete you will receive an email notification from Follow My Health that will give you instructions on how to register. We also have instruction sheets at the front desk on how to sign up for the patient portal. If you have any questions please call the office at **256-236-5631.**

**PATIENT SIGNATURE:** _____ **DATE:** _____