



1446 Lee Beard Way  
Augusta, GA 30901  
706-828-7468  
706-724-7566 (Fax)

**Dr. Sam Davis, CEO      Jean Callaway, Executive Director      Dr. Benjamin Rucker, Medical Director**

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Dear Patient,

We would like to take this opportunity to welcome you to our Medical Center. We want to assure you that we will do everything possible to make your visit a pleasant one. To accomplish this, we need your help.

- Complete the **Patient Registration Form**.
- Sign the **Medical Records Release Form**.
- Bring your **picture ID** and **health insurance card** with you to each visit.
- Pay the **co-payment and patient balance** at each visit.
- Bring **ALL medications** with you to each visit.
- Please call if you are going to be **over 30 minutes late**.
- Please allow **24 hours** for all prescription refills.
- Please **call 24 hours in advance** for cancellation.

Our doctors care for many patients and occasionally run late due to unexpected problems that you or other patients may have, so please be understanding when this occurs. You may want to bring reading material to occupy your time in the event your appointment is delayed. All of our patients have many questions and our staff tries to give every patient the time needed to address their concerns. We appreciate your patience during these busy times.

Again, welcome to Lamar Medical Center. If you have any questions or concerns, please call 706-828-7468.

Respectfully,

Lamar Medical Center Staff

**Mission:**

*To provide access to quality comprehensive, culturally diverse, and community-based primary care.*



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## PATIENT REGISTRATION

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ GENDER: Female \_\_\_\_\_ Male \_\_\_\_\_

Relationship Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Race (OPTIONAL): Black \_\_\_\_\_ White \_\_\_\_\_ Hispanic \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship \_\_\_\_\_

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Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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Primary Ins: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group ID# \_\_\_\_\_

Claim Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group ID #: \_\_\_\_\_

Claim Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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## **MEDICAL RELEASE FROM PRIOR HEALTHCARE PROVIDER**

I AUTHORIZE \_\_\_\_\_

TO RELEASE MEDICAL INFORMATION ON ME TO LAMAR MEDICAL CENTER.

I HEREBY RELEASE LAMAR MEDICAL CENTER FROM ALL LEGAL RESPONSIBILITIES OR  
LIABILITIES THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

**PATIENT'S NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_

\_\_\_\_\_  
**SIGNED**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**DATE**

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**Consent to the Use and Disclosure of Health Information, Payment or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notices to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be uses or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Patient/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**PRESENT ILLNESS**

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**PAST SURGICAL HISTORY**

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**MEDICATIONS (List Prescription and Over the Counter)**

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**Medical and Family History Form, page 2**

**MEDICAL HISTORY (Check all that apply to you)**

	High Blood Pressure		Low Blood Pressure		Chest Pain		Heart Attack
	Diabetes		Renal (Kidney Disease)		CVA (Stroke)		Thyroid Disease
	Palpitations		Syncope (Passing Out)		Shortness of Breath		Asthma
	COPD		Emphysema		Ulcers		Liver Disease
	Seizures		Vertigo (Dizziness)		Post Menopausal		Arthritis
	Gout		Stomach Problems		Cancer(s) *Specify Below*		

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**FAMILY HISTORY:**

**Mother:** \_\_\_\_\_

**Father:** \_\_\_\_\_

**Sister(s):** \_\_\_\_\_

**Brother(s):** \_\_\_\_\_

**PERSONAL DATA:**

**Occupation:** \_\_\_\_\_

**Smoking:** NO \_\_\_\_\_ YES \_\_\_\_\_      **Packs per day** \_\_\_\_\_      **# of years** \_\_\_\_\_

**Alcohol Intake** \_\_\_\_\_

**Diet:** \_\_\_\_\_

**Psychological Problems:** \_\_\_\_\_

**Children:**  
(ages/sex) \_\_\_\_\_

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