Airport Clinic, Inc. **NEW PATIENT INFORMATION** DATE: _____

Name: _____ DOB: ____/____/____
Last First Middle

Address: _____
Mailing address City State Zip Code

Social Security#: _____-_____-_____ Male___ Female___ Race: _____ Primary Language: _____

Single___ Married___ Divorced___ Widowed___ Separated____ Live with a partner_____

Occupation, description: _____ Highest Level of Education? _____
Primary Phone #_____ Work #_____Cell #_____
Emergency Contact: _____ Relation: _____ Phone# _____
Personal Email address:(optional) _____
Do you have a personal physician/specialist? No___ Yes___ If yes, Physician's name/phone #_____
Reason for visit. (If injured, describe in detail): _____
_____

1. Check whether you have had these conditions and describe in detail at on line #2.

	Y	N		Y	N		Y	N		Y	N
Asthma	☐	☐	Immune Disease	☐	☐	Depression	☐	☐	Sinus Problems	☐	☐
COPD	☐	☐	Hepatitis	☐	☐	PTSD	☐	☐	Menstrual Problems	☐	☐
Heart or Vascular Disease	☐	☐	Chronic Pain	☐	☐	Substance or Alcohol Abuse	☐	☐	DVT	☐	☐
High Blood Pressure	☐	☐	Fibromyalgia	☐	☐	Diabetes	☐	☐	Lung Blood Clots	☐	☐
High Cholesterol	☐	☐	Stroke	☐	☐	Thyroid Disease	☐	☐	Kidney Disease	☐	☐
Arthritis	☐	☐	Epilepsy	☐	☐	Intestinal Problems	☐	☐	Sleep Apnea	☐	☐
HIV	☐	☐	Anxiety	☐	☐	Skin Disease	☐	☐	Allergies	☐	☐

2. Details or other conditions? _____

3. Surgical History(type/year): _____ _____

4. Hospitalizations (reason/year): _____

5. Family History: Please **CIRCLE** any diseases that run in your immediate family and the family member who had them ☐ Adopted

High Cholesterol	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Diabetes	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Rheumatoid Arthritis/Osteo Arthritis	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Cancer(Kind?)	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Heart Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Thyroid Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other
Alcoholism/Drug Abuse/Bipolar Disorder/Anxiety/ Depression	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Kids	Other

List any other family medical history you are aware of: _____

Do you use tobacco products	Y	N	What Kind?	Packs per day?
Former Smoker?	Y	N	Amount Per Day?	How Many Years?
Do you drink alcohol?	Y	N	Do you drink, on average, 2 drinks a day? Y or N	Drink more than 5 drinks within 2 hours? Y or N
Do you do illicit drugs?	Y	N	If yes, what kind:	Former Drug User? Y or N

Airport Clinic, Inc.

704 Gil Harbin Ind. Blvd
Valdosta, GA 31601

(229) 242-9003
Fax (229) 242-0490

PATIENT IMMUNIZATION INFORMATION

Date: _____

Patient Name: _____

DOB: _____

Type	Received (YES OR NO)	Year
Td (Tetanus) /TDAP (Whooping Cough)		
Covid 1		
Covid 2		
1st Covid Booster		
2nd Covid Booster		
Flu		
Pneumovax23		
Prevnar20		
Shingrix 1 (Shingles)		
Shingrix 2 (Shingles)		
Hep A 1		
Hep A 2		
Hep B 1		
Hep B 2		
Hep B 3		

Airport Clinic , Inc. Patient Medication Sheet Date: _____

Name: _____ DOB: ____/____/____

Name of Pharmayc:_____

Pharmacy Information :_____

Street Name City State

List all drug or latex allergies & type of reaction, if any:

Name of Drug: Type of Reacion :

_____ _____

_____ _____

_____ _____

Please list below all prescribed medicines including inhalers, breathing machine soltions, ASA, over-the-counter medicines (nasal inhalers, eye drops, etc.) & any supplements, vitamins, minerals:

NAME OF MEDICATION	DOSAGE	TIMES/DAY	REASON FOR TAKING MEDICATION

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Payment Policy

To our private insurance patients:

If you have a yearly deductible on your health insurance policy that you have not met, payment for your visit will be due at the time of service. We will file your claim with your insurance company and apply your billed amount to your deductible. If you do not know that amount of your deductible or do not know if you have one, we will be glad to check with your insurance provider. Your patient during this process is appreciated. If we cannot verify the amount of your deductible, your insurance will be billed for the cost of the office visit. Any amount not paid by your insurance will be billed to you separately. Thank you for your cooperation in this matter.

To our cash/uninsured patients;

You must have means of payment available to you at the time of service. If you cannot afford to pay a minimum fee at the time of service, you may seek care in the emergency room. The hospital receives government support to assist low income patients.

To our Medicare Patients:

Under some conditions Medicare may not pay for services, procedures, or medications given in the office. Under these circumstances you may be billed separately for these services. You must signa waiver for this to occur and will be informed of the treatments which may not be covered at the time of service.

To Our Medicaid Patients:

If your Medicaid is assigned to another physician or medical office, we may need a referral number from the to treat you. A referral number lets your primary physician know what is being done for you and by whom. Under some conditions we may be unable to collect a referral number from your physician. If this occurs you may elect to wait and be seen at a later time by your primary doctor, have your Medicaid primary medical office changed to our facility or seek medical care in the emergency room.

Any payment denied by your financial institution will be assessed a $25.00 service fee in addition to original fees.

Please ask if you would like to arrange a payment plan for any amounts you will be billed. We will be happy to work with you.

_____	_____	_____
Print Patient Name	**Patient(guardian) Signature**	**Date**

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Medical Release Form

Date: _____

Records requested from:

_____

_____

_____

_____

I, _____**, hereby authorize and request that you relase the following information:**

_____

_____

_____

Release records to: **Airport Clinic, Inc**
704 Gil Harbin Industrial Blvd
Valdosta, Ga 31601
Phone: 229-242-9003
Fax: 229-242-0490

_____ _____
Patient Signature **Date of Birth**

_____ _____
Social Security # **Witness Signature**

Please contact our office with any questions
229-242-9003

Airport Clinic, Inc.

704 Gil Harbin Ind. Blvd
Valdosta, GA 31601

(229) 242-9003
Fax (229) 242-0490

Patient Name: _____ Date of Birth: _____
(Please Print Name) (Required)

I, _____ the undersigned, authorize: Airport Clinic, Inc. to disclose, in writing and/or verbal, protected health information (PHI) to:

_____

_____

_____

I understand I am authorizing the release of medical information to the above organization/company/employer and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/ consultation/ examination and/or diagnostic procedures performed at Airport Clinic, Inc. or information obtained from other medical providers providing treatment to me and which pertain to an injury/ occupational/ medical information for which might affect my ability to perform specified job duties for potential employment for _____.
I understand the information disclosed based on this authorization may include health treatment records and information regarding medical treatment or testing and prescribing medication s that might prohibit me from performing normal job duties.

I understand I have the right to inspect the PHI to be disclosed as permitted under the federal HIPAA law and state law. A copy of the medical information will be available to me or my physician of record upon your request from_____.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.
(No physicals exams can be performed for my potential employer without written consent.)

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION.
(In order to revoke this authorization, I may, at any time, send written notification to Airport Clinic, Inc. I understand that my revocation of this authorization is ineffective to the extent that Airport Clinic, Inc has relied on this authorization to disclose PHI relating to me.)

My signature below indicates that I have read and understand this Authorization.

_____ _____ _____
Print Patient Name **Patient(guardian) Signature** **Date**