625 W. Memorial Dr.
P.O. Box 182
Dallas, GA 30132-9998
www.carelinkga.org
678-903-5103
770-485-7553 (fax)
info@carelinkga.org

New Patient Application

Patient Eligibility

CareLink is currently registering adults 18+ with no insurance or Medicare Part A only as new patients.

Have you applied, or do you currently have Medicare or Medicaid Insurance?

Yes No

Patient Information

Name: ____

SS#: _____________________________ Birthdate: _______/________/________

Race: ____________________ Sex: Male Female Other

Home Address: ____

City, State:____________________ Zip: ________ Home Phone:________________

Work Phone: ____________________ Cell Phone: _________________________

E-mail: ____

Do you give permission for CareLink to send appointment reminders or requests for follow-up calls via Text or E-mail

Your Employer:_______________________________ Phone: __________________

Full Time or Part Time Gross Annual or Hourly Pay:_______________

Spouse's Name: ____

Spouse's Employer:_____________________________ Phone: _________________

Full Time or Part Time Gross Annual or Hourly Pay:_______________

Patient Emergency Contact

Name: ____

Contact Phone: __________________ Relation to Patient: _____________________

Patient Medical Status

Please list any medical conditions/diseases you have.

____

____

____

____

____

____

____

____

Please list all medications, herbals, and/or vitamins you are currently taking.

Name	Dose/Strength	How often do you take it?

Medication Allergies		Vaccinations			
Medication	Reaction	Name	Date	Name	Date
		Pneumococcal		Varicella	
		Influenza		Tetanus	
		Shingles		COVID	

Family History

Please list all family members including mother, father, sisters and brothers.

Check if Adopted

Family Member	Name	Medical Problems/ Diagnosis	Age	Deceased

Surgical History

Please list all surgeries or procedures you have had.

Date	Type of Procedure/ Hospitalization	Reason for Procedure/ Hospitalization	Hospital	Name of Surgeon

List any other Doctors or Specialists you are currently seeing.

____

____

____

____

____

Social History

Marital Status:

Current Status: Divorced Married Single Widowed

Do you live alone? Yes No

Previously Widowed: Yes No Previously Divorced: Yes No

Children: Yes No Number of Sons: _______ Number of Daughters: _______

Tobacco:

Are you a smoker? Yes No Former Years smoked: _______

Years quit: ______ Ever tried to quit? Yes No

Passive smoke exposure: Yes No Type: ____________________________

Do you use e-cigarettes? Yes No How frequently?__________________

Caffeine:

Do you drink caffeine? Yes No

Type: Coffee Tea Soda Chocolate Tablets High Caffeine Drinks

Alcohol:

Do you drink alcohol? Yes No Years quit: ______

Type: Beer Wine Hard Liquor

Frequency: _____________ Amount: ______________ Last Drink: ______________

Safety:

Are there working smoke detectors in the home? Yes No

Are there Carbon monoxide detectors in the home? Yes No

Is there Radon in the home? Yes No

Do you have firearms in the home? Yes No

Do you wear a seatbelt? Yes No

Recent Travel:

Any recent travel outside the state? Yes No Where? ____________________

Any recent travel outside the U.S. ? Yes No Where? ____________________

Lifestyle:

Activity Level: Sedentary Moderate Vigorous

Health club member: Now Previously Never

Type of exercise: ____

Exercise Frequency: _____________________ Duration: ________________________

Hobbies/Activities: ____

Specific type of diet: Low fat Low carb Diabetic Weight Watchers

Animals in the home: Yes No Type: ___________________________________

Are you the one who cleans up after the animal(s)? Yes No

Advanced Directives:

Mark the directives that you currently have in place:

None DNR Living Will Durable Power of Attorney HC Proxy

Do you agree to a transfusion? Yes No

Review of Personal Physical Health Systems

Have you experienced any of the following symptoms in the past month? Please answer Yes or No

	YES	or	NO
CONSTITUTIONAL			
Activity Change	______		______
Chills	______		______
Decreased appetite	______		______
Fatigue	______		______
Insomnia	______		______
Irritability	______		______
Malaise/ Feeling unwell	______		______
Night Sweats	______		______
Abdominal Paleness	______		______
Weakness	______		______
Weight loss	______		______
Weight gain	______		______
HEENT			
Headache	______		______
Eye Burning	______		______
Double Vision	______		______
Eye Discharge/ Draining	______		______
Eye Dryness	______		______
Foreign body sensation	______		______
Eye Itching	______		______
Rapid Eye Movement	______		______
Eye Pain	______		______
Sensitivity to light	______		______
Eye Redness	______		______
Visual halloes or blind spots	______		______
Spots/ floaters	______		______
Tearing	______		______
Glasses	______		______
Contacts	______		______
Vision loss	______		______
Radical Keratotomy	______		______
Lasik	______		______
Last eye exam	______		______
Ear discharge	______		______

	YES	or	NO
Cerumen/ Ear wax	______		______
Ear Fullness	______		______
Hearing loss	______		______
Ear Pain	______		______
Tinnitus/ Ringing in the ears	______		______
Vertigo/ dizziness	______		______
Noise exposure	______		______
NOSE AND SINUS			
Decreased smell	______		______
Nasal discharge/ drainage	______		______
Nose bleeding	______		______
Facial pain	______		______
Infections	______		______
Nasal congestion	______		______
Sneezing	______		______
THROAT AND MOUTH			
Taste change	______		______
Voice change	______		______
Cold Sores	______		______
Difficulty Swallowing	______		______
Hoarseness	______		______
Lump sensation	______		______
Pain when swallowing	______		______
Post nasal drip	______		______
Sore tongue/ tongue lesions	______		______
Sore Throat	______		______
Tooth pain/dentures/plates	______		______

	YES	or	NO
RESPIRATORY/THORAX			
Rapid breathing	______		______
Cough	______		______
Chest Pain	______		______
Frequent respiratory infections	______		______
Coughing up blood	______		______
Known TB exposure	______		______
Positive PPD/ TB test	______		______
Pain with breathing "stitch"	______		______
Shortness of breath	______		______
Wheezing	______		______
CARDIOVASCULAR			
Chest pain	______		______
Shortness of breath at rest	______		______
Shortness of breath on exertion	______		______
Sleep sitting up to breathe	______		______
Waking from shortness of breath	______		______
Swelling of hands and legs	______		______
Nighttime urination	______		______
Palpitations/rapid heart beat	______		______
Passing out	______		______
VASCULAR			
Cramping in legs when walking	______		______
Blue hands and feet	______		______
Flushing or redness of hands/feet	______		______
Cool extremities	______		______
Swelling of hands or legs	______		______
Pain in extremities	______		______
Ulcers in legs, feet ,and arms	______		______
Varicose veins	______		______
Blood clots	______		______

	YES	or	NO
GASTROINTESTINAL			
Abdominal Mass/growth	______		______
Abdominal pain	______		______
Altered bowel habits	______		______
Not eating or poor appetite	______		______
Black tarry stools	______		______
Bloating and feeling fullness	______		______
Blood in stool	______		______
Constipation	______		______
Diarrhea	______		______
Difficult or painful swallowing	______		______
Flatulence	______		______
Jaundice/yellow/hepatitis	______		______
Indigestion/ heartburn	______		______
Nausea	______		______
Weight loss	______		______
Hemorrhoids	______		______
Rectal bleeding	______		______
Vomiting	______		______
MUSCULOSKELETAL			
Back pain-neck, mid, low back	______		______
Bone/joint swelling or pain	______		______
Hands/wrist/elbow/shoulder /hips/feet/ankle swelling or pain	______		______
Muscle pain/ weakness	______		______
GENITOURINARY			
Back pain/flank/side pain	______		______
Change in color or cloudy urine	______		______
Urgency to urinate	______		______
Decreased or low urine stream	______		______
Foul urine odor	______		______
Urinating frequently	______		______
Pain when urinating	______		______
Mass in groin	______		______

	YES	or	NO
Blood in urine	______		______
Hesitancy or difficulty urinating	______		______
Urine leakage/incontinence	______		______
History of passing kidney stone	______		______

METABOLIC/ENDOCRINE

	YES	or	NO
Voice changes	______		______
Cold intolerance/feeling cold	______		______
Heat intolerance/feeling hot	______		______
Coarse Hair	______		______
Hair loss	______		______
Abnormal glucose/blood sugar tests	______		______
Abnormal fat distribution	______		______
Abnormal hair distribution	______		______
Chronically overweight	______		______
Chronically underweight	______		______
Clitoral enlargement	______		______
Darkening of skin	______		______
History of gout	______		______
Excessive perspiration	______		______
Excessive hunger	______		______
Excessive thirst	______		______
Generalized weakness	______		______
Gestational diabetes	______		______
Goiter	______		______
Gynecomastia/male breast enlargement	______		______
Low sugar reactions	______		______
Increase in size of feet and hands	______		______

HEMATOLOGIC

	YES	or	NO
Easy bruising	______		______
Easy bleeding	______		______
History of blood clots	______		______
Anemia or low blood count	______		______
Swollen lymph nodes	______		______

NEURO/PSYCHIATRIC

	YES	or	NO
Language disorder/difficulty talking	______		______
Unclear pronunciation	______		______
Focal weakness	______		______
Difficulty walking	______		______
Headaches	______		______
Incontinence	______		______
Un-coordination	______		______
Lightheadedness/dizziness	______		______
Loss of consciousness/fainting	______		______
Memory loss	______		______
Tingling/numbness	______		______
Seizures	______		______
Speech changes	______		______
Tremors	______		______
Vertigo/Hx of Meniere's	______		______
Visual changes	______		______
Lack of concentration	______		______
Do you have anxiety?	______		______
Do you feel fearful?	______		______
Do you feel excessively happy?	______		______
Do you feel paranoid?	______		______

FEMALE/WOMEN TO COMPLETE

	YES	or	NO
Age of first period?	______________		
Last menstrual period	______________		
Frequency of menstrual cycle	______________		
Are you post menopausal?	______		______
Have you previously used hormones	______		______
Have you ever used birth control	______		______
Have you ever had an abnormal PAP	______		______
Do you do self-breast exams	______		______
Lack of libido	______		______
Nipple discharge	______		______

	YES	or	NO
Breast lumps	______		______
Pain with sexual intercourse	______		______
History of uterine fibroids	______		______
Problems with infertility	______		______
Ovarian cysts	______		______
Sexual Dysfunction	______		______
Vaginal itching	______		______
Vaginal discharge	______		______
Sexually Active	______		______

DERMATOLOGIC

	YES	or	NO
Acne	______		______
Contact allergies	______		______
Hx of excessive sun exposure	______		______
Frequent skin/hair infections	______		______
Hair loss	______		______
Women: Facial hair	______		______
Nail change (brittle)	______		______
Change in skin color	______		______
Severe itching	______		______
Excessive sweating	______		______
Sensitivity to light	______		______
Rash	______		______
Lesions/tags/moles/freckles/ birthmarks	______		______

IMMUNOLOGIC

	YES	or	NO
Asthma	______		______
Hay fever	______		______
Hives	______		______
Anaphylaxis	______		______
Contact Dermatitis / rashes/ metal allergy	______		______
"Bee" sting allergy	______		______
If yes, reaction type?	______________		
Environmental allergies: Pollen/pollution	______		______
Animals in the home	______		______
Animal in the workplace	______		______
Chemicals in the home	______		______
If yes, type:	______________		
Chemicals in the workplace	______		______
If yes, type:	______________		

MALE/MEN TO COMPLETE

	YES	or	NO
Are you circumcised?	______		______
Erectile pain	______		______
Penile discharge	______		______
Blood in your stream	______		______
Scrotum/Testicular pain	______		______
Scrotum/Testicular mass	______		______
Hydrocele/fluid around testes	______		______
History of Herpes Genitalia	______		______
Problems with fertility	______		______
Have you ever been treated for an STD	______		______
Describe your sexual function:			
Normal	______		______
Decreased	______		______
Sexually Active	______		______

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS AND FINANCIAL RESPONSIBILITY FORM

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

I consent to routine medical procedures and treatments at CareLink of Northwest Georgia Inc., an outpatient 501c3, 100% volunteer run, primary care clinic. Routine procedures and treatments can include testing (for example blood sugar and urine tests), and evaluation (for example interviews and physical exams). However, this consent to routine procedures and treatments does not include consent for any other invasive procedures.

I understand that I may receive treatment and healthcare services given by CareLink volunteers (such as nurses and technicians) and by physicians and other independent medical professionals who are NOT CareLink employees. I understand that the healthcare services provided by these independent medical professionals, using independent medical judgment, at CareLink, in no way creates any type of employment partnership, or other relationship other than as an independent volunteer. These volunteers are responsible for their own actions and CareLink shall not be liable for the act or omissions of any such volunteer.

While I am a patient at CareLink, I understand that I may be observed by or receive healthcare services from students enrolled in training programs. Students are supervised by licensed instructors, Wellstar employees, or other independent medical professionals depending upon the training program the students are enrolled in. I understand that I have the right to request someone other than a student provide my care.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as a part of procedures or treatments given to me. I further understand that CareLink has no obligation to preserve these specimens; that it will retain or dispose of specimens according to practices.

I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with CareLink at any time). I understand the practice of medicine is

not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks or even death. I understand that no guarantees can be made as to the outcome of my care.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

CareLink expects a CASH payment for primary care services at the time of service. I understand that I am financially responsible for all other healthcare services. For example, the payment of non-covered services (i.e. lab and imaging orders), deductibles, and co-payments are the patient's responsibility. For healthcare services provided by independent medical professionals (for example Medical Specialty Groups and Procedures), I understand that I will receive separate bills and that I am responsible for paying them. I understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate, unless prohibited by law. I understand that CareLink of Northwest Georgia, Inc. is not responsible for any expenses that may be incurred based on our providers recommendation/orders.

Patient Name (Print)

____

Signature:

____**Date**:____________________

CareLink of Northwest Georgia (Print):

____

Signature:

____**Date**:____________________

A COMMUNITY HEALTH AND RESOURCE CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information about the Patient:

Patient Name: ____ DOB:____________
Last First Middle

Address: ____

The patient identified above herby authorizes CareLink of Northwest GA, Inc. ("practice") to release and disclose Patient's Protected Health Information, as defined by HIPAA ("PHI") to the following person or organization ("recipient"):

Name of Recipient of PHI: ____

Address: ____ Phone: _______________

This Authorization applies to the following PHI:

All Records pertaining to ____

Other ____

This Authorization applies only to the following dates of service: ____________________

This authorization applies only to the dates of service during the period of time from

______________ to _______________.

The disclosure of PHI will not include the following information unless the appropriate box is checked.

Any records for treatment for drugs or alcohol dependency or abuse.

Any record of mental health treatment, psychological services, or social services including communication to a social worker or psychologist.

Any record of testing or research pertaining to HIV, AIDS or other communicable disease(s).

Please provide PHI to recipient in the following manner. (hard copy by mail is default)

Mailed copy Faxed copy Electronic copy

Other ____________________ Electronic Format Requested ________________

Information about the person or organization authorizing the disclosure of PHI (if other than patient).

Name: ______________________ Relationship to patient __________________________

Documentation of relationship to patient attached.

Address: _______________________________ Phone: _____________________

I understand that (i) authorizing the disclosure of PHI to the Recipient is voluntary. (ii) this authorization covers multiple requests for the disclosures of PHI and authorizes the Practice to make such disclosures. (iii) I may refuse to provide authorization for disclosure of PHI to the Recipient, and Practice may condition treatment, payment for services, or eligibility for benefits on whether I sign this authorization. (iv) Any disclosure of PHI carries with it the potential for an unauthorized re-disclosure by the Recipient and the information may not be protected by federal or state privacy rules and (v) the Practice must provide a copy of this signed authorization to me.

The Authorization may be revoked at any time in writing by providing a signed revocation to Practice at 625 West Memorial Dr. Dallas, GA 30132. The Revocation is effective upon receipt but will have no impact on uses and disclosures of PHI made while the authorization was valid. This authorization shall expire one (1) year from the date of the Patient's last visit to Practice. For additional information on uses and disclosures of PHI by Practice please refer to our Notice of Privacy Practices.

I acknowledge and agree that if I refuse to provide this authorization or revoke this authorization prior to practice's disclosure of the PHI, Practice is not responsible for any consequences of failure to disclose any information to the recipient and is not responsible to notify me or any third party of any such consequences. I agree that I will not hold Practice and/or its agents responsible for any liability, loss, damage, or expense caused or incurred as a result of my refusal to provide this authorization, revoking this authorization, and/or in connection with any disclosure of PHI pursuant to this authorization.

Patient's Signature: _____________________________________ Date:_________________

Patient's Authorized Representative's Signature: ________________________ Date:__________

For office use only

If Patient is unable to sign, secure signature of the Next of Kin or Legal Agent/Guardian and indicate reason why patient is unable to sign.

☐ Minor ☐ Incompetent ☐ Disoriented ☐ Mentally Unstable

Processor's Initial's ________ Date Sent Out ________________

625 W. Memorial Dr.
P.O. Box 182
Dallas, GA 30132-9998
www.carelinkga.org
678-903-5103
770-485-7553 (fax)
info@carelinkga.org

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the patient acknowledges that he or she personally was offered and/or received a copy of CareLink of Northwest Georgia, Inc. 'Notice of Privacy Practices' on the date indicated below.

Patient Name (Print): ____

Signature: ___________________________________ Date: ____________

Information about Representative (attach appropriate documentation)

Representative: _______________________ Title: ____________________

FOR OFFICE USE ONLY

☐ Patient/Representative Unable to Sign – Notice of Privacy Practices Provided

☐ Patient/Representative Refused to Sign – Notice of Privacy Practices Provided

☐ Other: ____

CareLink Representative Signature: __________________________________

Print Name: ___________________________________ Date: ___________