Genesis Healthcare Associates, LLC

3200 Highlands Parkway Smyrna, GA 30080

Intake Form

Name_____ D.O.B._____

Reason for today's visit:

_____

What Specialist(s)do you see? (Name/Specialty/Date of last visit)_____

_____

Have you been to the ER/Urgent Care Visit since your last visit? Yes_____ No_____ If yes, please provide the name of the facility, location and the nature of the visit and/or the new medical diagnosis:

_____

Immunizations/Vaccines you expect today:

1.)_____ 2.)_____

Do you have any medications that need to be refilled? Yes____ No**____ If yes, please provide the name of the medication, dosage (ex:200mg every 8 hours) and how taken (ex: oral, injection, rectal, topical, ect.)**

1.)_____ Dosage:_____ How taken:_____

2.)_____ Dosage:_____ How taken:_____

3.)_____ Dosage:_____ How taken:_____

4.)_____ Dosage:_____ How taken:_____

Do you have any drug allergies? Yes_____ No_____ If yes, please list allergies / reaction:

_____

Do you currently have an Advanced Directive (living will) in place? Yes_____ No_____ If no, would you like more information? Yes_____ No_____.

Do you have a family history of cancer? Yes_____ No_____

Are you experiencing any pain? Yes_____ No_____ Rate your pain level, 1 (low)____10(high) ____

Please note: If you are here today for a Routine Physical Exam or a Well Child Check but require additional services (ex: EKG's, Spirometry, Chronic Disease Management, problem(s) or specific bloodwork, etc.) designed to facilitate your healthcare, you may incur additional charges. These charges may be applied toward your deductible, co-pay or co-insurance.

Signature:_____ Date_____