



Russell G.
O'Neal *Internal
Medicine*

1760 Bass Road, Suite 200A
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P: 478-309-1212 • F: 866-493-2791
www.russonealmd.com

PATIENT INFORMATION FORM

Last Name _____ First Name _____ M.I. _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Sex _____ Preferred Gender _____

Home Phone _____ Cell Phone _____

SSN _____ Date of Birth ____/____/____ Martial Status: S M W

Email _____ Previous PCP _____

Patient's Employer _____

Occupation _____ Work Phone _____

Race: Asian African American Hispanic White Other _____

Preferred Language _____ Ethnicity: Hispanic Not Hispanic

How did you hear about us? Billboard Family/Friends Internet Insurance Company

In Case of an Emergency

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number Home _____ Cell _____

Insurance Information

Primary Ins. Co _____

ID Number _____ Group Number _____

Subscriber's Name _____ DOB _____ Relationship _____

Secondary Ins. Co _____

ID Number _____ Group Number _____

Subscriber's Name _____ DOB _____ Relationship _____

Third Ins. Co _____

ID Number _____ Group Number _____

Subscriber's Name _____ DOB _____ Relationship _____

I authorize any holder of medical or other information about me to be released to my insurance company or the Social Security Administration needed for this or any related medical claim. I request payment of medical insurance benefits to Dr. Russell G. O'Neal. I understand that the charges are my responsibility. I understand that it is my responsibility to know if my physician is in network with my plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill.

Signature _____ Date _____

Patient Representative _____ Relationship _____



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MISSED APPOINTMENT POLICY

In order to take preventative measures and to help reduce misunderstanding between our patients and practice, we have adopted the following fee schedule. If you have any questions regarding this policy please discuss with our office manager.

Each time a patient misses an appointment without providing a proper notice, another patient is prevented from receiving care. Our system is set to call and/or text your reminders of your scheduled appointment. Due to high patient demand and limited availability of appointments we have instituted a “no show” fee.

You must give 24 hour notice to cancel or reschedule appointments. Failure to do so will result in a “no show” charge of \$50.00. This fee is billed directly to the patient and is not covered by insurance.

Patient Agreement: I have read and fully understand the no show policy of this practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Patient Name

Patient DOB

Patient Signature

Today's Date



Patient Name: _____ D.O.B: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
(Use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
2. Feeling down, depressed, or hopeless	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Feeling tired or having little energy	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Poor appetite or overeating	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

FOR OFFICE CODING 0 + Off + Off + Off
=Total Score: _____

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Provider Initials: _____



Patient Name: _____ D.O.B: _____

ANNUAL HEALTH RISK ASSESSMENT

During the past four weeks, how would you rate your health? Excellent Good Fair Poor

Which (if any) of the following are problems for you?

- I am tired or fatigued I experience a lot of stress or anger I am lonely or don't have a lot of support at home
 I have difficulty taking or remembering my medicines

Over the past two weeks, have you felt down, depressed or hopeless? Yes No

Over the past two weeks, have you felt little interest or pleasure in doing things? Yes No

Have you fallen in the past year? Yes No

Do you worry that you are at risk of falling? Yes No

Do you fasten your seatbelt when you are in a car? Yes No

Are you or your loved ones concerned about your memory? Yes No

Do you have any sexual problems you would like to discuss? Yes No

Do you have trouble with incontinence (leaking of urine)? Yes No

Do you need the help of another person to do any of the following? (Check all that apply)

- Make meals Shop for groceries or clothes Housework Drive/use public transportation
 Use the telephone Handle finances Take medications

Do you need the help of another person to do any of the following? (check any that apply)

- Eating Bathing Dressing Getting around your home Laundry Toileting Grooming

Do you have any problems with pain? Yes No

Do you have any problems with your vision or hearing? Yes No

Do you have any problems with your teeth or dentures? Yes No

Do you use tobacco (smoking, vaping, chewing)? Yes No

How many drinks of wine, beer or other alcoholic beverages do you have per week? 0-1 2-5 6+

Do you exercise for 20 minutes, three or more days per week? Yes Sometimes Never

Do you feel safe in your home? Yes No

What is your housing situation like? Live with 1 or more children Live in an assisted living facility Live in a nursing facility
 Live alone I have housing today, but I am worried about losing housing in the future I do not have housing

Do you follow any special diets (low sodium/low sugar)? Yes No

If so, what? _____

Do you take any opioid medications? Yes No

Do you have an Advance Directive? (health care proxy, living will) Yes No

Would you like to discuss Advance Directives today? Yes No