Capstone Medical Group

"A Personal Team for Your Personal Health"

www.CapstoneMedicalGroup.com

Clyde Watkins Jr. MD FACP
Karen Y. Luster MD FACP
Candace R. Wooten- Reed PA-C

2745 DeKalb Medical Parkway, Suite 200
Lithonia, GA 30058
404-446-3870 Office
404-446-3875 Fax

484 Irvin Court, Suite 241
Decatur, GA 30030
770-414-5611 Office
770-414-5612 Fax

WELCOME TO CAPSTONE MEDICAL GROUP

Welcome and thank you for giving us the opportunity to take care of you! We look forward to providing you with excellent medical care. Please take note of the important reminders noted below.

- Enclosed please find your New Patient Registration Forms. Please complete these in their entirety and bring them with you to your appointment. **The enclosed forms must be completed prior to your arrival in an effort to expedite your appointment.**
- You are required to **arrive 15 minutes prior to your appointment time.**
- Please remember to bring a valid picture id (Ex. Driver's License) and your current medical insurance and pharmacy cards.
- Please bring in all medications that you are currently taking. They will be returned to you prior to leaving your appointment.
- You will be required to pay all copay, coinsurance, and deductible amounts at the time of the visit.
- Please note that we **do not accept cash payments**. We accept visa, mastercard, checks and money orders.

Thank you.

Capstone Medical Group

"A Personal Team for Your Personal Health"

www.CapstoneMedicalGroup.com

Clyde Watkins Jr. MD FACP
Karen Y. Luster MD FACP
Candace R. Wooten- Reed PA-C

2745 DeKalb Medical Parkway, Suite 200
Lithonia, GA 30058
404-446-3870 Office
404-446-3875 Fax

484 Irvin Court, Suite 241
Decatur, GA 30030
770-414-5611 Office
770-414-5612 Fax

Name: _____

Date of Birth: _____ Sex: Male / Female (please circle)

Street Address: _____

City/State/Zip Code: _____

Preferred Contact #: _____ Alternate Contact#: _____

Social Sec. Number: _____ Marital Status: _____

May we leave a voicemail message regarding your lab results? YES / NO (please circle)

Employer & Work Contact #: _____

Emergency Contact Name/ Relationship: _____

Emergency Contact #: _____

Pharmacy Name & Location: _____

Your Email Address: _____

Capstone Medical Group

"A Personal Team for Your Personal Health"

www.CapstoneMedicalGroup.com

Clyde Watkins Jr. MD FACP
Karen Y. Luster MD FACP
Candace R. Wooten- Reed PA-C

2745 DeKalb Medical Parkway, Suite 200
Lithonia, GA 30058
404-446-3870 Office
404-446-3875 Fax

484 Irvin Court, Suite 241
Decatur, GA 30030
770-414-5611 Office
770-414-5612 Fax

Financial Policy
Payment of Services Agreement

- Effective January, 2012, we no longer accept cash payments. We do accept Visa, Mastercard, Checks and Money Orders.
- We will file your insurance as a courtesy, but please be aware that the patient is ultimately responsible for all visit fees. If the patient has medical insurance, Capstone Medical Group will accept assignment for the medical visit fees.
- Prior to services being rendered, the patient is responsible for their copay, coinsurance and deductible amounts that are not covered by their insurance plan. These amounts **will not** be billed to the patient.
- Any remaining patient account balances that exceed 60 days after the date of service will be released to a Collection Agency and the patient will be responsible for any and all collection agency and attorney fees.
- For services that **are not covered** by insurance, the practice requires payment of 100% prior to services being rendered.

No Show/Appointment Cancellation Policy

- Capstone Medical will assess a $35.00 NSF fee to all returned check payments.
- There is a $30 fee for each no show appointment.
- There is a $30 fee for each cancelled or rescheduled appointments that are made less than 24 hours prior to the scheduled appointment. Cancellations/reschedules must be made during the work week.
- No show and cancellation fees must be paid prior to the net scheduled appointment.

PLEASE READ THIS POLICY CAREFULLY PRIOR TO SIGNING.

By signing below, I acknowledge that I have read and understand this policy.

Signature: _____ Date: _____
(Patient / Responsible Party)

Capstone Medical Group

Clyde Watkins Jr. MD FACP
Karen Y. Luster MD FACP
Candace R. Wooten- Reed PA-C

Family History Questionnaire

Please complete the information below. Please check the box if the medical condition applies.

Family Member	Status (alive/ deceased/ unknown	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Father								
Mother								
Brothers								
Sisters								
Children								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								

Siblings **Brothers** ☐ **Sisters** ☐ ☐ **Healthy**

Children **Sons** ☐ **Daughters** ☐ ☐ **Healthy**

Notes / Additional Information

Capstone Medical Group
New Patient Questionnaire

Patient Name: _____ Date: _____

How did you hear about our office?

O Friend or Family. Name: _____
So that we may thank them

O Television Commercial

O Newspaper Ad

O Physician Referral. Name: _____

O Website Name: _____

Past Medical History: Please **CHECK** the "yes" box if any of the following illnesses apply.

	Yes	No		Yes	No
High blood pressure	O	O	Peripheral vascular disease	O	O
Heart attack	O	O	Congestive Heart Failure	O	O
Atrial fibrillation	O	O	High cholesterol	O	O
Mitral Valve Prolapse	O	O	Heart Murmur	O	O
Diabetes	O	O	Hypothyroidism	O	O
Graves disease	O	O	Hyperthyroidism	O	O
Goiter	O	O			
Glaucoma	O	O	Diabetic Eye Disease	O	O
Cataracts	O	O			
GERD	O	O	Vitamin B 12 Deficiency	O	O
Hepatitis	O	O	Cirrhosis	O	O
Pancreatitis	O	O	Diverticulosis	O	O
Irritable Bowel Disorder	O	O	Stomach Ulcers	O	O
Colon polyps	O	O			
Arthritis	O	O	Gout	O	O
Lupus	O	O	Rheumatoid Arthritis	O	O
Depression	O	O	Schizophrenia	O	O
PTSD	O	O	Bipolar Disorder	O	O
Alzheimer's Dementia	O	O			
Migraine headache	O	O	Carpal tunnel syndrome	O	O
Back pain	O	O	TIA	O	O

Stroke	O Yes O No	Seizures	O Yes O No
Multiple Sclerosis	O Yes O No	Parkinson's Disease	O Yes O No
Seasonal allergies	O Yes O No		
DVT	O Yes O No	Pulmonary embolism	O Yes O No
Sickle cell anemia	O Yes O No	Sickle cell trait	O Yes O No
Anemia	O Yes O No		
Kidney stones	O Yes O No	Enlarged prostate	O Yes O No
Renal failure	O Yes O No		
Osteoporosis	O Yes O No	Uterine fibroids	O Yes O No
Polycystic ovarian syndrome	O Yes O No	Endometriosis	O Yes O No
Heavy menstrual bleeding	O Yes O No		
Asthma	O Yes O No	Emphysema	O Yes O No
Sarcoidosis	O Yes O No	Pneumonia	O Yes O No
Obstructive Sleep Apnea	O Yes O No		
HIV/AIDS	O Yes O No	Genital herpes	O Yes O No
Syphilis	O Yes O No	Gonorrhea	O Yes O No
Chlamydia	O Yes O No		
Breast cancer	O Yes O No	Ovarian cancer	O Yes O No
Colon cancer	O Yes O No	Cervical cancer	O Yes O No
Prostate cancer	O Yes O No	Kidney cancer	O Yes O No
Lung cancer	O Yes O No		

Other conditions not listed above:

_____ _____

_____ _____

_____ _____

Surgical History: Please color the "yes" box to indicate if you have any of the following surgical procedures.

Appendix removal	O Yes Date: ____	Hysterectomy	O Yes Date: ____
Heart bypass	O Yes Date: ____	Mastectomy L_, R_	O Yes Date: ____
Gallbladder removal	O Yes Date: ____	Knee replacement L_,R_	O Yes Date: ____
Hip replacement L__, R__	O Yes Date: ____	Cataract removal	O Yes Date: ____
Heart valve replacement	O Yes Date: ____	Thyroid removal	O Yes Date: ____
Kidney removal	O Yes Date: ____	Ovary removal	O Yes Date: ____
Hernia repair	O Yes Date: ____	Fibroid removal	O Yes Date: ____
Prostate removal	O Yes Date: ____	Carpel tunnel repair	O Yes Date: ____
Rotator cuff repair	O Yes Date: ____	ACL repair	O Yes Date: ____

Other surgeries and dates performed that are not listed above:

_____

_____

_____

Allergies to any medications

_____

_____

_____

Medication List

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Smoking O Yes O No
Packs per day____Years smoked___Year quit_____

Second hand smoke expo O Yes O No

Alcohol O Yes O No
Exercise O Yes O No

Recreational drug use O Yes O No
What type _____
Type of exercise_____

Sexually active O Yes O No
Recent travel outside US O Yes O No

LMP_____ Last Pap_____

Review of Systems

General:	fever	O Yes O No	chills	O Yes O No
	weight gain	O Yes O No	weight loss	O Yes O No
	fatigue	O Yes O No		
ALLERGY;	runny nose	O Yes O No	itchy eyes	O Yes O No
	nasal congestion	O Yes O No	sneezing	O Yes O No
ENT:	nose bleeding	O Yes O No	hearing loss	O Yes O No
	ringing in ears	O Yes O No	sinus pain/drainage	O Yes O No
ENDO:	excessive thirst	O Yes O No	polyuria	O Yes O No
	cold intolerance	O Yes O No	heat intolerance	O Yes O No.
	sore throat	O Yes O No		
LUNGS:	shortness of breath	O Yes O No	cough	O Yes O No
	wheezing	O Yes O No	snoring	O Yes O No
CARDIAC:	chest pain	O Yes O No	palpitations	O Yes O No
	dizziness	O Yes O No	leg edema	O Yes O No
GI:	heartburn	O Yes O No	jaundice	O Yes O No
	diarrhea	O Yes O No	constipation	O Yes O No
	nausea	O Yes O No	vomiting	O Yes O No
	trouble swallowing	O Yes O No	blood in stool	O Yes O No
GYN:	hot flashes	O Yes O No	heavy periods	O Yes O No
GU:	blood in urine	O Yes O No	frequent urination	O Yes O No
	incontinence	O Yes O No	weak stream	O Yes O No
	nocturia	O Yes O No		
HEME:	easy bruising	O Yes O No	night sweats	O Yes O No
	swollen glands	O Yes O No	swollen lymph nodes	O Yes O No
M/S:	back pain	O Yes O No	joint pain	O Yes O No
	leg cramps	O Yes O No	joint swelling	O Yes O No
NEURO:	headache	O Yes O No	numbness/tingling	O Yes O No
	insomnia	O Yes O No	memory loss	O Yes O No
	fainting/blackouts	O Yes O No	tremors	O Yes O No
EYE:	blurring of vision	O Yes O No	double vision	O Yes O No
	eye irritation/redness	O Yes O No	eye pain	O Yes O No
MEN ONLY:	Low sexual drive	O Yes O No	erectile dysfunction	O Yes O No

Capstone Medical Group

Clyde Watkins Jr. MD FACP
Karen Y. Luster MD FACP
Candace R. Wooten- Reed PA-C

Authorization for Disclosure of Health Information

Patient Name (**Last, First, Middle**):
Date of Birth:
Social Security Number:
Street Address:
City, State and Zip Code:
Day/Evening Phone:

Physician/Facility - Information Released From **Physician/Facility - Information Released To**

Facility Name	**Facility Name**
	Capstone Medical Group
Street Address	2745 DeKalb Medical Parkway Suite 200 Lithonia, GA 30058
	484 Irvin Court Suite 241 Decatur, GA 30030
Phone	404-446-3870
Fax	404-446-3875

Please indicate information requested.

- All Records
- Progress Notes/ Lab Reports
- Discharge Summary/ Operative Report (s)
- History & Physical
- Medication List/Problem List
- Radiology/Pathology Report(s)
- STD/HIV Information
- Other: _____

_____ _____
Patient/Legal Representative Signature Date

***This Release of Records will expire one year from Signature Date.**