*** PATIENT INFORMATION SHEET ***

D.W. TIMMS, MD PC
310 EISENHOWER DR.,#3
SAVANNAH, GA. 31406

D.W. TIMMS, M.D.

M R. TIMMS, M.D

(PLEASE PRINT)

NAME
LAST:_____FIRST:_____INITIAL:___

ADDRESS:_____ APT#_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:(____)_____-_____ CELL PHONE:(____)____-_____

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY#____-___-_____

MARITAL STATUS: ___Married ___Single ___Other SEX:____M ____F

SPOUSE OR
NEAREST RELATIVE:_____RELATIONSHIP:_____

ADDRESS:_____

CITY:_____ STATE:____ ZIP:_____

EMPLOYMENT STATUS:____Yes ____No STUDENT:____YES____NO

EMPLOYER:_____ WORK PHONE#_____

ADDRESS:_____

CITY/ST/ZIP:_____

SPOUSE EMPLOYER:_____PHONE #_____

ADDRESS:_____

CITY/ST/ZIP:_____

REFERRED BY:_____

COMPLAINT:_____

_____

NUMBER OF INSURANCE PLANS COVERING PATIENT:___0 ___1 ___2 ___3

(COMPLETE INSURANCE INFORMATION ON BACK)

****INSURANCE PLAN ONE INFORMATION****

SUBSCRIBER NAME: _____
INSURANCE NAME: _____
ADDRESS: _____
CITY/ST/ZIP: _____

PLAN/GROUP NUMBER: _____

INSURANCE ID NUMBER: _____

****INSURANCE PLAN TWO INFORMATION****

SUBSCRIBER NAME: _____ DOB: _____
INSURANCE NAME: _____
ADDRESS: _____
CITY/ST/ZIP: _____

PLAN/GROUP NUMBER: _____

INSURANCE ID NUMBER: _____

AGREEMENT TO PAY - ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION

>>Patients who carry health insurance (Medicare, HMO, PPO, etc.) should understand that all professional services, NOT COVERED UNDER YOUR INSURANCE POLICY, are rendered & charged to the patient, not insurance.
>>All necessary insurance forms will be completed by D.W. timms, M.D., P.C., to help expedite insurance carrier payments. If a balance remains on the patient's account, the patient will receive a statement for the balance.
>>D.W. Timms, M.D., P.C., cannot accept responsibility for collecting insurance claims, (EXCEPT MEDICARE & ASSIGNED AMOUNTS), or negotiate any settlement on a disputed claim.
>>I assign to D.W. Timms, M.D., P.C., all rights and claims for reimbursement of expenses allowable under any insurance plan of which I am entitled. I authorize D.W. Timms, M.D., P.C., to release to insurance companies medical information for the processing and substantiation of patient's health benefit plan. I authorize the provider to execute any documents necessary to process said claims for benefits.

_____

DATE: _____ SIGNATURE: _____
(Patient or Parent/Guardian)

E-Mail Address: _____

HEALTH HISTORY

NAME: _____ SOCIAL SECUIRTY #: _____ DATE: _____

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

HAVE YOU EVER HAD OR, DO YOU HAVE ANY OF THE FOLLOWING?

		YES	NO			YES	NO
1.	ALLERGIES			24.	BLOOD CLOTS		
2.	HEAD INJURIES			25.	VARICOSE VEINS		
3.	SEIZURES			26.	LEG CRAMPS		
4.	FAINTING SPELLS			27.	BROKEN BONES		
5.	HEARING PROBLEMS			28.	ARTHRITIS, BURSITIS, NEWUITIS		
6.	CHRONIC EAR INFECTIONS			29.	BONE OR JOINT DEFORMITIES		
7.	VISION PROBLEMS			30.	DIABETIS		
8.	FREQUENT NOSE BLEEDS			31.	HYPOGLYCEMIA (LOW BLOOD SUGAR)		
9.	FREQUENT SORE THROATS			32.	LUNG DISORDER		
10.	ASTHMA			33.	HIGH BLOOD PRESSURE		
11.	HAY FEVER			34.	TENDENCY TO BLEED EASILY		
12.	DIZZINESS			35.	HOSPITALIZED (REASON & DATES)		
13.	BACK PAIN			36.	SURGERY (REASON & DATES)		
14.	BACK INJURIES			37.	MEDICATION WITHIN LAST MONTH		
15.	NERVE PROBLEMS			38.	RECEIVED WORKERS COMPENSATION		
16.	SKIN RASHES OR SENSITIVITY TO SUN			39.	INJURIED ON THE JOB (TYPE/LOST TIME)		
17.	HEART TROUBLE OF ANY KIND			40.	NO. OF DAYS MISSED DUE TO ILLNESS (PER Yr)		
18.	RAPID OR IRREGULAR HEARTBEAT			41.	SMOKE (NUMBER OF PACKS PER DAY)		
19.	FREQUENT HEARTBURN			42.	ALCOHOL COMSUMPTION (AMOUNT PER WEEK)		
20.	ULCERS			43.	HEPATITIS (YELLOW JAUNDICE)		
21.	FREQUENT CONSTIPATION/DIARRHEA			44.	CHRONIC HEALTH PROBLEMS		
22.	HERNIAS / RUPUTURES			45.	WEIGHT PROBLEMS (OVER OR UNDER)		
23.	KIDNEY STONES OR INFECTIONS			46.	FEAR OF HEIGHTS		

COMMENTS: _____

_____

PLEASE LIST ANY CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRIMARY CARE PHYSICAN: _____

FAMILY HISTORY

HAS ANYONE IN YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SISTERS, BROTHERS, WIFE, CHILDREN) EVER HAD ANY OF THE FOLLOWING CONDITIONS? CHECK YES OR NO. IF YES, PLEASE INDICATE RELATIVE AND BRIEFLY THE ILLNESS (AGE AT ONSET, DURATION, ETC.)

YES	NO		
		TUBERCULOSIS	
		HIGH BLOOD PRESSURE	
		HEART TROUBLE	
		EPILEPSY OR SEIZURES	
		DIABETES	
		HAY FEVER OR HIVES	
		MIGRAINE HEADACHES	
		MENTAL DISORDERS	
		TUMOR OR CANCER	

D.W. TIMMS, M.D., P.C.
M.R. TIMMS, M.D.
310 EISENHOWER DR #3
SAVANNAH, GA. 31406-2632
912 354-2104

D. W. TIMMS, M.D., P.C.
Eisenhower Drive Medical Center
310 Eisenhower Drive, Bldg. 3
Savannah, GA 31406
Telephone: 354-2104

D.W. Timms, M.D.
M.R. Timms, M.D.

Practice Limited to General
Vascular and Laparoscopic Surgery

Managed care mandates that you use in-network physicians, labs, hospitals and services in order to receive in-network payment.

Failure to notify your phyisician of in-network requirements will result in non-payment or penalty payment by your insurance company and will result in your being billed for services rendered.

If referral numbers and/or authorization for service requests are required by your plan, please notify this office prior to any service being rendered so that you will not be penalized.

Thank you for providing us with this information.

Please circle your INSURANCE COMPANY'S preferred lab:

Lab Corp Smith Kline Beecham St. Joseph's/Candler Labone Quest

_____Other

Please Circle your INSURANCE COMPANY'S preferred hospital:

St. Joseph's/Candler Memorial Medical Center

I have read the above information and understand that I am responsible for notification of my insurance plan mandates. I ALSO UNDERSTAND THAT IF I PROVIDE THE INCORRECT LAB/HOSPITAL INFORMATION, THE BILL FOR SUCH SERVICES WILL BE MY RESPONSIBILITY.

_____

NAME DATE

PATIENT CONSENT FORM

D.W. TIMMS, M.D., P.C.
M.R. TIMMS, M.D.
310 EISENHOWER DR #3
SAVANNAH, GA. 31406-2632
912 354-2104

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ SSN: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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