William Headley, MD
825 S First St
Jesup, GA 31545
912.427.7400
www.jesupdoctor.com

Heard About Us: ☐ **Newspaper** ☐ **Radio** ☐ **Friends/Family** ☐ **Dr. Referral**

☐ **Other:**_____

Name: _____ _____ _____
(Last) **(First)** **(M.I.)**

Home Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Social Security Number: _____-_____-_____ **Date of Birth:** ____/____/_____

Home Phone #: _____ **Mobile #:** _____ **Spouse:** _____

SEX: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Employer/Occupation/City: _____ **Work Phone #:** _____

E-mail:_____

Race: _____ **Ethnicity:** ☐ **Hispanic origin** ☐ **not Hispanic**

Primary Language: _____

***Please list your preferred pharmacy**_____

EMERGENCY INFORMATION:

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____

***RESPONSIBLE PARTY INFORMATION: (FOR A CHILD OR IF INSURED IS NOT THE PATIENT)**

Name: _____ **Relationship to Patient:** _____

Address: _____
Street **City** **State** **Zip**

Phone: _____ **Social Security #:** _____-_____-_____ **DOB:** _____

***(IF INSURED IS SOMEONE OTHER THAN THE PATIENT, PLEASE BE SURE TO INCLUDE ALL OF ABOVE INFORMATION)**

HEADLEY FAMILY MEDICINE

OFFICE POLICIES

Welcome to Headley Family Medicine. Thank you for choosing us for your healthcare needs. To have a smooth and pleasant navigation of the health system, we want you to be aware of our clinic policies and procedures. We are not gatekeepers. We are your advocate.

Office Hours are Monday through Thursday, 8:15 a.m. to 4:45 p.m. and Friday from 8:15 a.m. to noon. We are closed from 12 noon to 1:15 for lunch. We will close on major holidays. If you have a life-threatening emergency, please call 911. Non-emergency messages may be left on the voice mail, and calls will be returned the next business day.

We strive to serve you promptly and on time. Please arrive 5-10 minutes prior to your appointment in order for our nurse to update your records and review your medications. To efficiently handle your concerns, bring your medications, prescription renewals needed, and the issues you want addressed at the time of the visit. Upon arrival, check in at the front desk so we may give you appropriate attention.

Medical records are requested before the first appointment to ensure optimal transition of care. Make sure that your previous physician's office has complied with the request. Dr. Headley will review those records at the time of your visit.

Copays and deductibles must be paid at the time of appointment. If you cannot make your required copay and deductible, we will have the option of rescheduling your appointment. We accept cash, checks, MasterCard, Visa, Discover, and American Express.

On prescription refills, call your pharmacy for refills one week before you run out of medications. The pharmacy will notify the doctor's office of prescription renewal request. Refills are not considered emergencies and are taken care of during regular business hours. Refills will be denied unless the patient is seen within the past 12 months for those with chronic medical issues.

Medications that require prior authorization take about a week to get processed by the insurance company after the request has been received. It is your responsibility to contact your insurance carrier with questions regarding what medications they cover. Bring a copy of preferred medications from your insurance company on the day of your appointment. To ensure your safety, an appointment **is necessary** when requesting to change medications due to cost or formulary change.

A live person answers all phone calls received at the office during clinic hours. We do not use automated machines to answer our phones. To minimize phone traffic, it is appreciated if all issues can be addressed in one phone call.

Dr. Headley may order blood tests and other ancillary tests prior to an appointment. If you fail to have them done, notify our office to reschedule your appointment. Dr. Headley aims to discuss test results, give recommendations for treatment, and address your questions and concerns during the appointment to maximize satisfactory outcome. From time to time, you may request a copy of your tests. We do not have unlimited resources to keep reproducing those records, so make a file for yourself as you may need them for your other appointments.

Dr. Headley does not admit to the hospital or make rounds at the hospital. Wayne Memorial Hospital has full-time hospitalists who admit and take care of our patients until they are discharged. The hospitalist may communicate with Dr. Headley if needed. Copies of you hospital records will be available to us when you are discharged so that there is continuity of care.

HEADLEY FAMILY MEDICINE

NO SHOW/CANCELLATION POLICY

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a **No Show/Cancellation Policy** for our patients.

Please be advised that you are allowed one no show or same day cancellation appointment at which we will gladly reschedule without charges. On your second no show or same day cancellation, you will be charged a $25 fee that must be paid prior to making any new appointments. On your third no show or same day cancellation you will be charged a $25 fee and/or we reserve the right to terminate the patient-doctor relationship at this office. This fee is NOT covered under any insurance policy, strictly out of pocket cost for patient.

We understand that everyone might have an unforeseen event in which you cannot make it to your appointment. We have allowed that one grace appointment in which you are not charged a fee for that sudden emergency. For subsequent missed appointments, we are charging the nominal fee to cover for the staff that is on hand to provide for your needs. Please be assured that we want to run this office as efficiently as possible in order to provide you with the best care; and that this policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

Signature:_____ Date:_____

HEADLEY FAMILY MEDICINE

825 S First St
Jesup, GA 31545
Phone (912)427.7400
Fax (912)385.2953
www.jesupdoctor.com

Dear Patient:

Since you have made plans to become a patient of Dr. Headley and there are some things that must be done in order for us to do our best for you.

Please fill out the new patient form as completely as possible. This is most *important.* Please include all information on any illnesses, surgeries, doctors seen in the past, and most important, MEDICATIONS you are taking. Please bring those medications in the bottles.

When you come for your appointment, we need your completed new patient form, your photo ID, your insurance cards, and medications.

Being prepared will make your visit go more smoothly and enable Dr. Headley to better serve you. If you come unprepared, we may have to reschedule your visit.

Thank you very much.

Jessica Priest
Office Manager

Name: _____

Date: _____

Reason for Visit: _____

Past Medical History (Check box and indicate date of diagnosis):

Heart/ Blood Vessels
☐ High Blood Pressure _____
☐ Heart Block _____
☐ Congestive Heart Failure _____
☐ Heart Attack _____
☐ Heart Murmur _____
☐ Irregular Rhythm _____
☐ Peripheral Vascular Dse_____
☐ Varicosities _____
☐ Atrial Fibrillation _____

Lungs
☐ Pulmonary Fibrosis_____
☐ Frequent bronchitis_____
☐ Pneumonia_____
1) COPD_____
2) Asthma_____

Digestion/Bowels
☐ Acid Reflux_____
☐ Hernia_____
☐ Gastritis/Ulcers_____
☐ Constipation_____
☐ Irritable Bowel Syndrome_____
☐ Colitis_____
☐ Diverticulitis_____
☐ Pancreatitis_____
☐ Polyps_____
☐ Hemorrhoids_____
☐ Hepatitis_____
☐ Gall Bladder stones _____

Urinary
☐ Bladder Incontinence_____
☐ Infertility_____
☐ Kidney Stones_____
☐ Venereal Dse/STD_____

Male
☐ Prostate Enlargement_____
☐ Impotence/E.D. _____

Female
☐ Cystic Breast_____
☐ Endometriosis_____
☐ Sexual Problems_____
☐ Ovarian Cyst_____
☐ Uterine Fibroids_____

Glands
☐ Thyroid Disorder_____
☐ High Cholesterol_____
☐ Diabetes (frequency blood sugar checked)____
☐ Osteoporosis_____

Skin
☐ Rash or Eczema
☐ Warts_____
☐ Skin Cancer_____
☐ Chickenpox_____
☐ Psoriasis_____
☐ Shingles_____

Ears/Nose/Throat Allergy
☐ Hearing Loss R/L_____
☐ Sinus Problems_____
☐ Nasal Injury_____
☐ Asthma_____
☐ Allergic Rhinitis_____

Eye
☐ Macular Degeneration_____
☐ Cataracts R/L_____
☐ Glaucoma_____
☐ Retinopathy_____

Brain/Nerves
☐ Migraine_____
☐ Parkinson's _____
☐ Stroke_____
☐ Dementia_____
☐ Seizures_____

Past Medical History (*Continued)*:

Muscles/Bones
☐ Osteoarthritis_____
☐ Rheumatoid Arthritis_____
☐ Herniated Disc_____
☐ Tendinitis_____
☐ Gout_____
☐ Temporal Arthritis_____
☐ Fibromyalgia_____
☐ Systemic Lupus_____
☐ Foot Problems_____

Blood/ Cancers
☐ Anemia_____
☐ Cancer_____
☐ Blood Clots_____

Psychological
☐ Bipolar_____
☐ Obsessive-Compulsive Disorder_____
☐ Depression_____
☐ Anxiety/Panic_____

Any other conditions not mentioned above:

_____

_____

_____

_____

_____

_____

Past Surgical History (Check box and please indicate date of surgery):

Head and Neck
☐ Brain_____
☐ Lasik_____
☐ Tonsils_____
☐ Thyroid_____
☐ Cataract_____
☐ Sinus_____
☐ Adenoids_____

Past Surgical History *(Continued):*

Heart and Circulation (Please include dates and which hospital if known)
☐ Carotid_____
☐ Heart Bypass_____
☐ Pacemaker_____
☐ Angioplasty_____
☐ Defibrillator_____

Pulmonary/Allergy
☐ Lung R/L_____
☐ Bronchoscopy_____

Gastrointestinal
☐ Appendix_____
☐ Hemorrhoid surgery_____
☐ Gall Bladder_____
☐ Hernia repair_____

Genito-urinary
☐ Bladder_____
☐ Prostate_____
☐ Kidney Stones_____
☐ Vasectomy_____

Musculoskeletal
☐ Carpal Tunnel Repair_____
☐ Joints (Please specify)_____
☐ Foot_____
☐ Spine_____
☐ Other_____

Skin
☐ Rash or Eczema_____
☐ Skin Cancer_____
☐ Psoriasis_____
☐ Warts_____
☐ Chickenpox_____
☐ Shingles_____

Other surgical procedures not asked above:

_____

_____

_____

_____

_____

Health Promotion

Last Physical Date_____
Pap/Pelvic Date_____
Mammogram Date_____
PSA Date_____
Bone Density/DXA scan Date_____
Colonoscopy Date_____

Immunization History

Tetanus Date_____
Hepatitis B Series Date_____
HPV (Gardasil) Vaccine Date_____
Measles/Mumps/Rubella Date_____
Flu Shot Date_____
Pneumovax Date_____
Zostavax/Shingles Vaccine Date_____

Drug Allergies

1._____ Reaction:_____

2.._____ Reaction:_____

3._____ Reaction:_____

Latex allergy ☐ yes ☐ no

Food allergy ☐ yes ☐ no
type:_____

Procedures (Specify type and date of exam)

Allergy testing_____
Cardiac catheterization_____
Cystoscopy_____
EMG/Nerve Condition_____
EEG_____
IVP_____
Pulmonary function_____
Ultrasound_____
Barium enema_____
CT Scan_____
Echocardiogram_____
Upper GI Endoscopy_____
Hearing test_____
MRI_____
Stress test_____
X-ray_____

Other test you have had that are not mentioned above:

_____

_____

_____

_____

_____

_____

Family History

Father: Age_____ ☐ living ☐ deceased
Health Status_____
Medical conditions _____

Mother: Age_____ ☐ living ☐ deceased
Health Status_____
Medical conditions_____

Brothers_____ ☐ living ☐ deceased
Health Status_____
Medical conditions_____

Family History (Continued)

ADAVANCE DIRECTIVES:

Do you have a living will ? ☐ yes ☐ no
Do you have a Power of Attorney for health care?
☐ yes ☐ no
Designated to: (Name/Phone #)

_____

HABITS:

Smoking ☐ Never_____ cigarettes a day; _____
Since when?_____ Quit in:_____

Alcohol ☐ yes ☐ no Servings per week:_____
(1 serving = 12 oz beer = 5 oz wine = 1.5 oz liquor)
Quit in: _____

Sisters_____ ☐ living ☐ deceased
Health Status_____
Medical conditions_____

Daughters_____ ☐ living ☐ deceased
Health Status_____
Medical conditions_____

Sons_____ ☐ living ☐ deceased
Health Status_____
Medical conditions_____

Personal and Social History

Marital status: Single, Married, Widowed, Divorced? _____

Level of Education:_____
Occupation;_____
Religious affiliation:_____
Pets: ☐ yes ☐ no
Military service ☐ yes ☐ no

Caffeine_____ cups/day_____
Soda/day_____what kind_____

Street drug ☐ yes ☐ no
type:_____
Exercise ☐ yes ☐ no
type:_____

Sleeping problem:
☐ Falling asleep ☐ Staying asleep ☐ Snoring
☐ No problem

Seatbelt:
☐ Always ☐ Never

Occupational exposures:
☐ Body fluid ☐ Fumes ☐ Chemical

Method of Contraception:

_____
_

IF 65 YEARS OR OLDER (please check the correct boxes)

Living arrangement: ☐ home ☐ senior housing ☐ assisted living ☐ group home ☐ nursing home
Assistive devices: ☐ none ☐ cane ☐ walker ☐ wheelchair

Functional History

Activities of daily living-independent with:
☐ Bathing ☐ Dressing
☐ Grooming ☐ Eating
☐ Ambulating ☐ Transfers
☐ Hygiene ☐ Continence

Instrumental activities of daily living- independent with:
☐ Telephone use ☐ Shopping
☐ Housework ☐ Meal preparation
☐ Managing finances ☐ Taking medications
Ability to drive ☐ yes ☐ no

Other concerns you wish to discuss with your doctor:

_____
_____
_____
_____

I certify that the above information to be true and correct to the best of my knowledge.

_____ _____
Signature Date

MEDICATIONS – *Currently taking (including inhalers)*

Name	Dosage	Frequency

Over the counter products and herbal medicines

Name	Dosage	Frequency