HYPERBARIC AND REHABILITATIVE MEDICINE

PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT

Last Name	**First Name**	**MI**
Social Security Number	**Date of Birth**	
Address		
City	**State**	**Zip**
Home Phone	I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information. ☐ **YES** ☐ **NO**	
Cell Phone	I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information. ☐ **YES** ☐ **NO**	
Email Address		
Employer	**Work Phone**	
Race ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Latino** ☐ **Multiracial** ☐ **Native American** ☐ **Other**		
Ethnicity ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Not Reported/Refused**		
Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Separated**		
Gender ☐ **Male** ☐ **Female** ☐ **Transgender MTF** ☐ **Transgender FTM** ☐ **Genderqueer** ☐ **Other**		

EMERGENCY CONTACT INFORMATION:

Name (first and last)	Relationship	Phone

PARENT / LEGAL GUARDIAN / POA / RESPONSIBLE PARTY (if applicable):

Name (first and last)	Relationship	Phone

CURRENT PHYSICIANS: **Please list ALL of your current physicians (first and last name) and their contact information.**

Physician Name	Specialty	Phone

Patient's Signature **Date**

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CURRENT MEDICATIONS

NAME **DATE OF BIRTH**

PHARMACY **DATE**

PHARMACY PHONE NUMBER

Please list current medications <u>including</u> over-the-counter medications, vitamins and supplements, if applicable:

MEDICATION NAME	DOSAGE (example: 50 mg)	FREQUENCY (example: once daily)	Date to be Completed

ALLERGIES: **Please check the appropriate box(es) and provide additional information if applicable.**

☐ None ☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Other (*please list below*)		

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PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING PRIVACY PRACTICES

I understand that the patient's health information is private and confidential. I understand that HyOx Medical Treatment Center, Inc. (HyOx), Richard W. King, Jr., MD (Dr. King) and Marianne Taryla, MD (Dr. Taryla) in conjunction with the staff and other intermittent physicians, work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that HyOx and Drs. King and Taryla may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

HyOx, Dr. King and Dr. Taryla have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

HyOx, Dr. King and Dr. Taryla may update this Acknowledgment and "Notice of Privacy Practices". If I ask, HyOx, Dr. King and/or Dr. Taryla will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods or alternative location.

HyOx and Drs. King and Taryla have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist HyOx and Drs. King and Taryla by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of HyOx and Dr. King's and Dr. Taryla's "Notice of Privacy Practices".

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	

AUTHORIZATION TO TREAT

I consent to examination, treatment, and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or designated provider.

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	

HYPERBARIC AND REHABILITATIVE MEDICINE

FINANCIAL POLICY

I understand that dive physicals are not covered by insurance and are a personal expense that varies based upon the requirements of the physical.

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	
Guarantor (if not self) Georgia Aquarium	**Guarantor DOB**

CONSENT TO SPEAK

I, _____, authorize Dr. Richard W. King, Jr., Dr. Marianne Taryla and the clinical staff at HyOx Medical Treatment Center to discuss information related to my medical care with the following family members/caretakers:

NAME	RELATIONSHIP	PHONE

This authorization will not expire unless revoked by you or your legal representative or upon notification of death.

Patient's Signature	**Date**
Witness Signature	**Date**

HYPERBARIC AND REHABILITATIVE MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records to:

Richard W. King, Jr., M.D.
Marianne Taryla, M.D.
HyOx Medical Treatment Center

☐ 2550 Windy Hill Rd., Suite 110
Marietta, GA 30062
Phone: 678.303.3200
Fax: 678.303.3205

☐ 500 Medical Center Blvd., Suite 170
Lawrenceville, GA 30046
Phone: 678.672.1640
Fax: 678.672.1647

Printed Name	**DOB**
Patient's Signature	**Date**
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)	

HYPERBARIC AND REHABILITATIVE MEDICINE

DIVING MEDICAL HISTORY FORM
(Page 1)

Name _____ Gender _____ Age _____ Weight _____ Height _____

Date of Birth _____ Sponsor/Facility ____Georgia Aquarium, Inc._____

TO THE APPLICANT

Diving makes considerable demands on your physical and emotional condition. Diving with certain medical conditions may be asking for trouble, not only for yourself but also for anyone coming to your aid if you get into difficulty in the water. Therefore, it is prudent to meet certain medical and physical requirements before beginning a diving or training program.

Your answers to the questions are as important, in many instances, in determining your fitness as what the physician may see, hear or feel when you are examined. Obviously, you should give accurate information or the medical screening procedure becomes useless.

This form will be kept confidential. If you believe any question(s) amounts to invasion of your privacy, you may elect to omit an answer, provided you discuss the matter with the physician; and they must then indicate, in writing, that you have done so and that no health hazard exists.

If your answers indicate a condition(s) that might make diving hazardous, you will be asked to review the matter with your physician. In such instances, their written authorization will be required in order for further consideration to be given to your application. If your physician concludes that diving would involve undue risk for you, remember that they are concerned only with your well-being and safety. Respect this advice and the intent of this medical history form.

	Yes	No	Please indicate whether or not the following apply to you	Comments
1			Trouble with your ears, including ruptured eardrum, difficulty clearing your ears, or surgery	
2			Trouble with dizziness	
3			Eye surgery	
4			Depression, anxiety, claustrophobia, etc.	
5			Substance abuse, including alcohol	
6			Loss of consciousness	
7			Epilepsy or other seizures, convulsions or fits	
8			Stroke or a fixed neurological deficit	
9			Recurring neurological disorders, including transient ischemic attacks	
10			Aneurysms or bleeding in the brain	
11			Decompression sickness or embolism	
12			Head injury	
13			Disorders of the blood, or easy bleeding	
14			Heart disease, diabetes, high cholesterol	
15			Anatomical heart abnormalities including patent foramen oval, valve problem, etc.	
16			Heart rhythm problems	
17			Need for pacemaker	

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DIVING MEDICAL HISTORY FORM
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	Yes	No	Please indicate whether or not the following apply to you	Comments
18			Difficulty with exercise	
19			High blood pressure	
20			Collapsed lung	
21			Asthma	
22			Other lung disease	
23			Diabetes mellitus	
24			Pregnancy	
25			Surgery	
26			Hospitalizations	
27			Do you take medications?	
28			Do you have allergies to medications, foods, and environments?	
29			Do you smoke?	
30			Do you drink alcoholic beverages?	

Please explain "yes" to any of the above questions.

I certify that the above answers and information represent an accurate and complete description of any medical history.

Applicant Signature **Date**

HYPERBARIC AND REHABILITATIVE MEDICINE

POST COVID-19 SCREENING FORM

Complete only if you have had Covid-19 since your last dive physical.

Name: **Date of Birth:**

For symptoms you experienced while ill. If N/A leave blank:

Fever or chills	Mild	Moderate	Severe	Symptom Onset Date:	
Cough	Mild	Moderate	Severe	Positive Test Date:	
Shortness of breath / trouble breathing	Mild	Moderate	Severe	Last Symptom Date:	
Fatigue	Mild	Moderate	Severe	Return to Work Date:	
Muscle or body aches	Mild	Moderate	Severe		
Headache	Mild	Moderate	Severe	Asymptomatic	Yes / No
Loss of taste or smell	Mild	Moderate	Severe		
Sore throat	Mild	Moderate	Severe	Sought Medical Treatment	Yes / No
Sinus congestion or runny nose	Mild	Moderate	Severe		
Nausea or vomiting	Mild	Moderate	Severe	Chest X-ray Performed	Yes / No
Diarrhea	Mild	Moderate	Severe		
Chest Congestion	Mild	Moderate	Severe		
Persistent pain or pressure in the chest	Mild	Moderate	Severe		
New confusion	Mild	Moderate	Severe		
Inability to wake or stay awake	Mild	Moderate	Severe		
Discolored skin, lips, or nail beds	Mild	Moderate	Severe		

If treatment was sought, please explain:

Applicant's Release

By my signature below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge. I also understand that any false statements or deliberate omissions on this form may subject me to harm. I also consent to the release of this information and all medical information subsequently acquired in association with my diving to the Georgia Aquarium's Diving Safety Office and Diving Control Board.

Applicant Signature **Date**