PATIENT'S CLINIC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PAtient's clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

I_____

give Patient's Clinic, INC. and office staff at 1532 West Andrew Johnson Hwy permission to discuss my medical condition (please list family members and friends only) with

Name_____relationship_____
phone number_____

Name_____relationship_____
phone number_____

Patient's Clinic

Patient Authorization of Release of Medical Information

Patient's Name:	Date of Birth:	Social Security Number:
Address:	Telephone Number:	

I hereby authorize employees, Medical Staff members or other agents of PatientFirst Clinic (Facility Name) to use or disclose the following protected health information:

(√) Copy of the Complete Record (s)
□Progress Note □ Discharge Summary □ Lab Results □History/Physical Examination
□ Operative Report □ Pathology Report □ Radiology Reports/Film (s)
□ Other as specified below: □ Emergency Department Record (s)

To be used by or released to: PATIENT'S CLINIC 1532 WEST AJ HWY MORRISTOWN,TN 37814
FAX # 423-353-1177 PHONE 423-353-1175

For the following purpose:
√)At the Request or Direction of the undersigned individual
□For Marketing-This organization will/will not (cross out one) receive compensation,whether monetary or otherwise,as a result of the use or disclosure of your health information for marketing.
□For Research (describe)
□Other (describe)

*If this form authorizes the use or disclosure of psychotherapy notes,it may not be used to authorize the use or disclosure of any other Protected Health Information. A separate authorization is needed for any other use or disclosure.
*This authorization also includes any information in my medical records regarding diagnosis/treatment of alcohol/drug abuse, phsychiatric mental illness,immunodeficiency syndrome (AIDS) or tests for human immunodeficiency virus (HIV).

This Authorization expires:
□On the following date: ____/____/____
□When the following even occurs:
□No Expiration (permitted only for authorizations used to create or maintain research databases or repositories)
*Unless otherwise specified,this authorization will expire six (6) months from the date signed by patient or legal authorized agent, and covers only treatment prior to that date.

You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use of disclosure. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy.

If the only reason you have asked us to provide a health care service is so we can create information to be disclosed to a third party,we may have refuse to provide the service if you refuse to sign this authorization. Example - If you have requested a drug test soley for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authroization permitting us to disclose the results to your employer.

I understand this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my ability to receive treatment,payment,enrollment in a plan, or eligibility for a benefit except as stated above.

I understand that signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

Patient's Signature Date Witness Date

*The above individual is unable to consent because: □Minor □Incompetent □Other (explain)
I hereby consent on behalf of the patient name on this authorization"

Signature Date Relationship Witness Date

PATIENT'S CLINIC INC.

1532 West Andrew Johnson Hwy,Morristown, TN 37814
Phone (423)353-1175 Fax (423)353-1177

Name: _____ Date of Birth: ___/___/___ Age: ____ Sex: ____
How did you hear about our practice?

Pharmacy Name & Number_____

Please briefly state in the box below the reason for your visit

Past Medical History

Condition / Disease	Year Began	Condition / Disease	Year Began

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	Month / Yr	Operation / Hospitalization / Injury	Month / Yr

Other Physicians and Specialists

List below your other physicians (i.e., Eye, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

Medication or Food Allergies or Intolerances

List below medications or foods causing an allergic reaction (i.e. rash, swelling, or intolerance (i.e. nausea))

Medication / Food	Reaction	Medication / Food	Reaction

Medications, Vitamins and Herbal Supplements

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

Social, Educational and Work History

Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	

Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

✦ Family Health History ✦

Please list below the health history of your blood (genetic) first degree relatives.

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

✦ Review of Systems ✦

Please review the following symptoms and check those items that are a problem for you.

Hepatitis C with hepatic coma	Agranulocytosis secondary to cancer chemotherapy	Alcoholism	Allergic Rhinitis	Allergy to Peanuts
Allergy to Seafood	Anemia	Aneurysm of unspecified site	Anxiety	Arthritis
Asthma	Atherosclerosis	Atrial Fibrillation	Celiac Disease	Chest Pain
Chronic Kidney Disease	C.O.P.D	Circulatory system disorder	Colon Cancer	Congestive Heart Failure
Coronary Artery Aneurysm	Crohn's Disease	Cushing's syndrome	Depression	Diabetes
Diabetes mellitus	Emphysema	Gastroesophageal reflux disease	Gout	Headache
Hearing loss	Heart attack	Heartburn	Hepatic Failure	Herniated Disc
High Blood Pressure	High Cholesterol	High Lipids	Hypertension	Hypothyroidism
Hyperthyroidism	Insomnia	Irritable bowel syndrome	Kidney Failure	Lung Cancer
Migraine	Mitral Valve disorder	Mumps arthritis	Mumps Hepatitis	Obstructive sleep apnea
Osteoporosis	Stroke	Subclinical iodine-deficiency	Sinusitis	Transitory neonatal

✦ Disease Prevention and Health Maintenance ✦

Please list below the most recent dates of your vaccines and health screening tests.

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Ht:
Wt:
BP:
O2:

Temp:
Hr:

Patient's Clinic
1532 West Andrew Johnson Highway
Morristown, TN 37814
423-353-1175

Patient Medical Record Documentation and Your Email Address

As part of Patient's Clinic commitment to ensuring accurate and complete electronic medical records, we need to collect an email address as part of your patient information.

Use of Email Addresses

In this age of technological communication, email addresses are as common - if not more so – than phone or fax numbers. As email use becomes more prevalent, Patient's First must ensure it maintains complete and comprehensive records – including contact information – to communicate with patients under certain circumstances.

Your email address will not be sold to other entities for any reason or otherwise provided to third parties for non Patient's Clinic use unless required for legal reasons. Just as Patient's Clinic takes the security of your health information seriously, we commit to responsibly maintaining and using your email address and contact information.

We may communicate with you periodically about important health topics. However, patient medical information will not be communicated using your email address.

Patients who do not have an email address should denote below and sign this form, which will remain on file as part of their patient record.

Confirmation of Email Address

Primary Email Address (required) _____@_____
Secondary Email Address (optional) _____@_____

☐ I do not have an email address.

Patient Signature: X _____ Date: _____ Time: _____

Assignment Of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Patient First INC for medical or surgical services or items rendered to me or my dependent by Patient First INC. Should my insurance carrier deny Patient First INC payment, I understand that I am financially responsible for the charges. I authorize Patient First INC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

X _____

Patient's Clinic, INC
1532 West Andrew Johnson HWY
Morristown, TN 37814

Please review the Financial Policy:

1. Self pay patients will pay at time of service. Copay's are due at the time of service. No exceptions.
2. If you do not show for an appointment you will be charged $25.00 per no show. After 3 no shows you may be discharged from the practice
3. If you have a yearly deductible you will need to pay at time of service. The remaining balance will be due after the insurance processing is complete.
4. If payment plans are established and are not kept current, the account will be considered for collection and dismissal as a patient.
5. FLMLA forms $10.00 and Disabilities forms $25.00 to be completed.
6. When calling in for treatment that results in a prescription (ex: antibiotic) There will be a $15.00 charge.
7. There will be a fee of $30.00 for returned checks. If we receive a return check, you will no longer be able to pay with another check for payment. You will need to pay with cash, money order, or credit card.
8. I agree that the staff of Patient's Clinic, INC. may leave a message at my home or cell number.
9. I agree that Patient's Clinic. INC. may email me for appointment reminders

I have reviewed and understand the financial policy. I understand that I have been provided/offered with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFED.

Patient Signature _____ Date _____