Tennessee Family Clinic

# Patient Registration

First Name_____Last Name_____ MI_____Date of birth_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

May we leave a message on your Home Phone Cell Phone Work Phone None (Please circle all that apply)

Best # to reach you_____ Confidential Email_____

*Race American Indian Asian Native American African American White Hispanic Other

*Ethnicity Hispanic Not Hispanic Refuse to answer * Preferred Language_____

*Government Requires this information to protect patients against discrimination.

Pharmacy of choice_____Location of pharmacy_____Phone_____

Gender M F Marital Status S M W D SSN_____

Employer name_____ Full Time Part Time Not Employed Student

Emergency Contact_____ Relationship_____Phone_____

How did you hear about us?_____

Person responsible for the bill_____

SSN_____ DOB_____Home #_____Cell#_____

Address_____City_____State_____Zip_____

Primary Insurance_____ID#_____Group#_____

Policy holder_____Relationship to patient_____DOB_____

Address_____City_____State_____ZIP_____

Home Phone_____Cell Phone_____Employer_____

Secondary Insurance_____ID#_____Group#_____

Policy Holder_____Relationship to patient_____DOB_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work_____

I hereby authorize (a) payment of insurance benefits to be made directly to Tennessee Family Clinic ,PLLC (b)release of information including protected health information to insurance companies as needed to file payment for services incurred,(c) Tennessee Family Clinic, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment , and (d)understand that I am financially responsible to Tennessee Family Clinic, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party)_____Date_____

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## Health History Questionnaire

Name: _____ □M □ F DOB: _____
Marital Status: _____ Referred by: _____Occupation: _____

### Medical & Family History:

Have you or any of your family members had:

| Self | Fam | | Self | Fam | |
|---|---|---|---|---|---|
| □ | □ | High Cholesterol | □ | □ | Tuberculosis |
| □ | □ | Heart Disease | □ | □ | Intestinal Problems |
| □ | □ | Stroke | □ | □ | Breast Problems |
| □ | □ | High Blood Pressure | □ | □ | Bladder Problems |
| □ | □ | Diabetes | □ | □ | Infertility |
| □ | □ | Cancer | □ | □ | Endometriosis |
| □ | □ | Asthma | □ | □ | Lupus |
| □ | □ | AIDS (HIV) | □ | □ | Blood Transfusion |
| □ | □ | Hepatitis | □ | □ | Domestic Violence |
| □ | □ | Blood Disorder | □ | □ | Abnormal Pap Smear |
| □ | □ | Osteoporosis | □ | □ | Abnormal Mammogram |
| □ | □ | Seizures | □ | □ | Genital Warts |
| □ | □ | Migraines | □ | □ | Herpes |
| □ | □ | Depression | □ | □ | Gonorrhea |
| □ | □ | Psychiatric Illness | □ | □ | Chlamydia |
| □ | □ | Thyroid Problems | □ | □ | Sexual Problems |

Other:_____
_____
_____

### Which of these symptoms have you experienced in the **past year**:

□ Chills
□ Weakness
□ Chest Pain
□ Shortness of Breath
□ Persistent Cough
□ Nausea/ Vomiting
□ Diarrhea
□ Constipation
□ Rectal Bleeding
□ Difficulty Sleeping
□ Indigestion
□ Snoring
□ Blood in Urine
□ Poor Appetite
□ Stomach Pain
□ Swelling ankles
□ Blurred Vision
□ Difficulty Swallowing
□ Ear Pain
□ Joint Pain Location:
_____
_____

### Hospitalizations:

Please list any operations or serious illnesses requiring hospitalization:

Month/Year Illness/Operation

_____
_____
_____
_____
_____

Please list ALL MEDICATIONS you are taking:

_____
_____
_____
_____
_____
_____

### Health Habits:

Exercise:
□ Sedentary □ Mild □ Occasional □ Regular

Alcohol:
How many drinks per day? _____
Have you considered cutting back? □ Y □ N
Have people annoyed you by criticizing your drinking? □ Y □ N
Have you ever felt guilty about your drinking? □ Y □ N
Do you sometimes drink in the morning as an "eye-opener" or to settle your nerves? □ Y □ N

Tobacco:
□ Cigarettes- _____packs/day for _____ years
□ Chew- _____packs/day for _____ years
□ Pipe- _____packs/day for _____ years
□ Cigars _____packs/day for _____ years

Drugs:
Do you use any street or recreational drugs? □ Y □ N
Have you ever given yourself street drugs with a needle? □ Y □ N

Childhood Illness:
□ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever
□ Polio

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## Health History Questionnaire, Continued

Advanced Directives:

□ None □ Do not Resuscitate □ Durable Power of Attorney □ Living Will □ HC Proxy

Vaccinations:

□ Influenza Date: _____ □ Shingles Date: _____

□ Pneumonia Date: _____ □ Tetanus Date: _____

Allergies to Medications:

_____

_____

Sexual History:

Currently sexually active? □ Y □ N With: □ Men □ Women □ Both Number of Current Partners: _____

Have you ever been sexually abused of raped? □ Y □ N

### Women Only

Contraceptive History:

| Past | Present | |
|---|---|---|
| □ | □ | Birth Control |
| □ | □ | IUD |
| □ | □ | Diaphragm |
| □ | □ | Condoms |
| □ | □ | Spermicidal |
| □ | □ | Norplant |
| □ | □ | Depo-Provera |
| □ | □ | Tubal Ligation |
| □ | □ | None |
| □ | □ | Other: _____ |

Gynecologic/Obstetric History

If you are post-menopausal, check here, and skip to question #5: □ post-menopausal

1. Date of last Menstruation: _____
2. Period every _____days
3. Flow can be described as:
   □ mild □ moderate □ heavy
4. Are you pregnant or breast feeding? □ Y □ N
5. Number of pregnancies: _____
6. Number of full-term births: _____
7. Number of pre-term births: _____
8. Have you had a urinary tract, bladder, or kidney infection in the past year? □ Y □ N
9. Experienced recent breast tenderness? □ Y □ N
10. Experiences recent nipple discharge? □ Y □ N

Date of last Pap Smear: _____

Date of last Bone Density Test: _____

Date of last Mammogram: _____

Date of last Colonoscopy: _____

### Men Only

1. Do you get up in the middle of the night to urinate? □ Y □ N How many times? _____
2. Do you feel pain or burning with urination? □ Y □ N
3. Do you feel burning discharge from your penis?
   □ Y □ N
4. Has the force of urination decrease?
   □ Y □ N
5. Do you have any problems emptying your bladder completely? □ Y □ N
6. Have you had any bladder or kidney infections in the past year? □ Y □ N
7. Any difficulty with erection or ejaculation? □ Y □ N
8. Any testicle pain swelling? □ Y □ N

Date of last prostate and rectal exam:

_____

Date of last PSA test:

_____

Date of last colonoscopy:

_____

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## Consent for Release of Prescription History

I authorize Tennessee Family Clinic to access my prescription history from outside sources to help keep my medical records as complete as possible. This includes many but not necessarily all medication used in the past.

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Name Signature Date

☐ Yes, I give Tennessee Family Clinic permission to discuss my medical condition(s), me treatment, and information regarding my appointments, and my financial account with the following:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

☐ No, I do not give permission for Tennessee Family Clinic to discuss my medical care or treatment with anyone other than me.

### Privacy Practices

Please note that our Patient Privacy Practice is posted in our waiting room for everyone to view. You may request a copy for your records. My signature below indicates I have been give the opportunity to review a current copy of the Tennessee Family Clinic, PLLC "Notice of Privacy Practices".

### No Show Policy

We require 24 hour notice of cancellation for appointments. No show appointments are visits that could have been given to other patients that need our services. You will receive a courtesy letter for your 1st no show. You will receive a $25 bill for your 2nd no show. If you have multiple no shows, you can be dismissed from this practice.

### Consent to Treat

I hereby authorize Tennessee Family Clinic, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment. I hereby release Tennessee Family Clinic, PLLC and its physicians and/or staff

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## General Consent for Care and Treatment Consent

***TO THE PATIENT:*** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identity the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntary request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinic Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

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# Financial Policy

Patient Name_____DOB_____

Thank You for choosing Tennessee Family Clinic, PLLC.

It Is our policy that all fees including co-pays, deductibles and non- covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does not release the patient from responsibility for charges for services that have been provided. Please make sure we have a current copy of your insurance card. If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment. It is your responsibility to verify if our office is in network with your plan.

Accounts not paid within a reasonable period of time, and for which no special arrangements have been made will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to terms set forth.

1. I understand my co-pay, deductible or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for those charges.
3. If my insurance does not pay, I understand I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to collection agency I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collection, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for scheduled appointment or give 24- hour cancellation notice, I will receive one-time courtesy notice. For a second no show appointment, I understand I will receive a bill for the missed appointment, I understand a third missed appointment is grounds for dismissal from the practice.

I authorize the release of information from my medical records in order to comply with applicable law, the performance of utilization review and quality assurance activities and to facilitate third party accreditation/certification activities. I accept responsibility for the medical charges incurred and agree to pay all bills at the time of service unless other arrangements have been made. I authorize physician and /or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and or authorized Medicare benefits to be paid directly to Tennessee Family Clinic, PLLC. I further agree that a photo copy of this document is to be considered as valid as an original.

_____

Patient signature or responsible party Date

_____

**Tennessee Family Clinic, PLLC**

**275 Pickwick Street**

**Savannah, TN 38372**

**P: (731) 727-8366 F: (731) 727-8367**

**Katherine Forsbach, FNP-C**

## Authorization for Release of Medical Information

**Patient Name**:_____

**Address**:_____

**Birthday**:_____

**SSN**:_____

I authorize _____to release my medical information to Katherine Forsbach FNP at Tennessee Family Clinic, 275 Pickwick Street, Savannah, TN 38372.
I understand that this information is to be disclosed for the following purposes only:

_____
_____

I authorize the release of information pertaining to any hospitalizations/office visit(s), including specifically the following portions of the records:

_____

_____

_____

I understand that I may revoke the consent to release of information at any time, however I also understand that any release which has made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

**Patient Signature**:_____

**Date**:_____

**Witness**:_____