

Patient Registration Form

PATIENT INFORMATION

Physician _____

(Please Print)

 Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated OtherSocial Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day EveningCellular _____ Pager _____ May we contact you at work? Yes No

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

Do You Have A Living Will? Y N

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

StoneCrest Family Physicians

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **StoneCrest Family Physicians** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **StoneCrest Family Physicians** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **StoneCrest Family Physicians**.

I acknowledge that I have been given the **StoneCrest Family Physicians** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

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

Patient (or Responsible Party) Signature

Date



CHRISTOPHER O. THOMPSON, M.D.
Family Medicine

BRYAN J. KOZINSKI, M.D.
Family Medicine

PETER F. COBB, M.D.
Family Medicine

JOSHUA M. HIXSON, M.D.
Family Medicine

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May StoneCrest Family Physicians and/or members of the office staff release medical information to specified persons other than you? Yes___ No___

If yes, please specify to whom this information may be released.

Authorized Person

Relationship to You

What information may be released ?

Lab results Yes___ No ___

X-ray reports Yes___ No ___

Medications Yes___ No ___

Medical status Yes___ No ___

Appointments Yes ___ No ___

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

Patient Signature

Date

New Patient Info Form

Patient: _____
 Date: _____

Ht: _____ Wt: _____ Temp: _____
 Hp: _____ / _____ Pulse: _____

HISTORY

CHIEF COMPLAINT:

HISTORY of PRESENT ILLNESS: • For an “Extended” history, document at least four of these elements

- | | |
|--|--|
| <ul style="list-style-type: none"> • Location _____
(Where is the pain/problem?) • Severity _____
(How severe is the pain/problem?) • Timing _____
(Does this pain/problem occur at a specific time?) • Associated signs/symptoms _____
(What other associated problems have you been having?) | <ul style="list-style-type: none"> • Quality _____
(Example: color of sputum) • Duration _____
(How long have you had this pain/problem? or when did it start?) • Context _____
(Where were you at the onset of this pain/problem?) • Modifying factors _____
(What makes this pain/problem worse or better? or have you had any previous episodes?) |
|--|--|

MEDICAL HISTORY:

- For a “Pertinent” history - at least 1 specific item for ANY ONE of the 3 histories
- For a “Complete” history - at least 1 specific item for EACH ONE of the 3 histories

• *Patient Medical History*

Diabetes.....	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions.....	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal disease	No	Yes
Hereditary defects	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries	When?
_____	_____
_____	_____
_____	_____

Medications

• *Patient social history*

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Use of alcohol: Never ____ Rarely ____ Moderate ____ Daily ____

Use of tobacco: Never ____ Previously, but quit ____ Current packs/day ____

Use of drugs: Never ____ Type/Frequency _____

Excessive exposure at home or work to: Fumes ____ Dust ____ Solvents ____ Air-borne particles ____ Noise ____

• *Family Medical History*

	<u>Age</u>	<u>Disease</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Document the positive & pertinent negative responses

- For an "EXTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state: "All other systems negative")

SYSTEM REVIEW:

• CONSTITUTIONAL SYMPTOMS

Good general health lately.....No Yes
Recent weight changeNo Yes
FeverNo Yes
FatigueNo Yes
HeadachesNo Yes

• EYES

Eye disease or injuryNo Yes
Wear glasses/contact lensNo Yes
Blurred or double visionNo Yes
Glaucoma.....No Yes

• EARS/NOSE/MOUTH/THROAT

Hearing loss or ringingNo Yes
Earaches or drainingNo Yes
Chronic sinus problems or rhinitisNo Yes
Nose bleedsNo Yes
Mouth soresNo Yes
Bleeding gumsNo Yes
Bad breath or bad tasteNo Yes
Sore throat or voice change.....No Yes
Swollen glands in neckNo Yes

• CARDIOVASCULAR

Heart troubleNo Yes
Chest pain or angina pectorisNo Yes
PalpitationNo Yes
Shortness of breath with walking or lying flatNo Yes
Swelling of feet, ankles or handsNo Yes

• RESPIRATORY

Chronic or frequent coughs.....No Yes
Spitting up blood.....No Yes
Shortness of breathNo Yes
Asthma or wheezingNo Yes

• GASTROINTESTINAL

Loss of appetiteNo Yes
Change in bowel movementsNo Yes
Nausea or vomitingNo Yes
Frequent diarrheaNo Yes
Painful bowel movements or constipationNo Yes
Rectal bleeding or blood in stoolNo Yes
Abdominal pain or heartburnNo Yes
Peptic ulcer (stomach or duodenal)No Yes

• GENITOURINARY

Frequent urinationNo Yes
Burning or painful urinationNo Yes
Blood in urineNo Yes
Change in force of strain when urinatingNo Yes
Incontinence or dribblingNo Yes
Kidney stonesNo Yes
Sexual difficultyNo Yes
Male - testicle painNo Yes
Female - pain with periodsNo Yes
Female - irregular periods.....No Yes
Female - vaginal bleeding.....No Yes
Female - # of pregnancies _____ # of miscarriages _____
Female - date of last pap smear _____

• MUSCULOSKELETAL

Joint PainNo Yes
Joint stiffness or swellingNo Yes
Weakness of muscles or joints.....No Yes
Muscle pain or cramps.....No Yes
Back painNo Yes
Cold extremities.....No Yes
Difficulty in walkingNo Yes

• INTEGUMENTARY (skin, breast)

Rash or itching.....No Yes
Change in skin colorNo Yes
Change in hair or nails.....No Yes
Varicose VeinsNo Yes
Breast painNo Yes
Breast lumpNo Yes
Breast discharge.....No Yes

• NEUROLOGICAL

Frequent or recurring headachesNo Yes
Light headed or dizzyNo Yes
Convulsions or seizuresNo Yes
Numbness or tingling sensationsNo Yes
TremorsNo Yes
ParalysisNo Yes
StrokeNo Yes
Head injuryNo Yes

• PSYCHIATRIC

Memory loss or confusionNo Yes
NervousnessNo Yes
DepressionNo Yes
Insomnia.....No Yes

• ENDOCRINE

Glandular or hormone problemNo Yes
Thyroid diseaseNo Yes
DiabetesNo Yes
Excessive thirst or urinationNo Yes
Heat or cold intolerance.....No Yes
Skin becoming dryerNo Yes
Change in hat or glove sizeNo Yes

• HEMATOLOGIC/LYMPHATIC

Slow to heal after cutsNo Yes
Bleeding or bruising tendency.....No Yes
Anemia.....No Yes
PhlebitisNo Yes
Past transfusionNo Yes
Enlarged glandsNo Yes

• ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibioticsNo Yes
Morphine, Demerol, or other narcoticsNo Yes
Novocaine or other anestheticsNo Yes
Aspirin or other pain remediesNo Yes
Tetanus antitoxin or other serumsNo Yes
Iodine methiolate or other antisepticsNo Yes
Other drugs/medications _____
Known food allergies _____