New Patient Paperwork

Legal last name_____Legal first name_____First name used_____

Middle name, suffix_____Previous name (last, first)_____ Legal sex_____

DOB_____SSN_____

Address_____

ZIP code_____City_____State_____

Home phone_____Mobile phone_____Consent to text ___Yes__No

Work phone_____Patient email_____

Consent to call indicates whether the patient has agreed to receive automated phone calls from your practice on their mobile phone. Depending on the features your practice offers, phone calls may be about appointments, test results, and more. ___Yes___No Medication History Authority ____Yes____No

Emergency Contact Name_____Relationship_____

Home phone_____Mobile phone_____

Language Preferred _____ ____Patient Declined

Race _____ ____Patient Declined

Ethnicity _____ ____Patient Declined

Marital status_____Sexual orientation_____

Gender identity _____Assigned sex at birth_____Pronouns_____

Homebound? ____Yes____No

Employer name _____Employer phone_____

Guardian Information

Last name_____First name_____Middle name, suffix_____

Guarantor Information (name to whom statements are sent)

Patient's relationship to guarantor_____Guarantor Last name_____

First name_____Middle name, suffix_____DOB_____

Address_____

ZIP code_____City_____State_____SSN_____

Phone_____Email_____Employer_____

Insurance Policy Holder Information

Patient's relationship to policy holder_____Last name_____

First name_____Middle name, suffix_____SSN_____

DOB_____Sex_____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____
Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY
1._____
2._____
3._____
REACTION
_____
_____
_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
STRENGTH
_____
_____
_____
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FREQUENCY TAKEN
_____
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_____
_____

PAST MEDICAL HISTORY

Please check all that apply:

Anxiety Disorder
Arthritis
Asthma
Bleeding Disorder
Blood Clots (or DVT)
Cancer
Coronary Artery Disease
Claustrophobic
Diabetes - Insulin
Diabetes - Non-Insulin
Dialysis
Diverticulitis
Fibromyalgia
Gout
Has Pacemaker
Heart Attack
Heart Murmur
Hiatal Hernia or Reflux Disease
HIV or AIDS
High Cholesterol
High Blood Pressure
Overactive Thyroid
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Pulmonary Embolism
Reflux or Ulcers
Stroke
Tuberculosis
Other

PAST SURGICAL HISTORY

SURGERY
1. _____
1. _____
3. _____
4. _____

REASON
_____
_____
_____
_____

YEAR
_____
_____
_____
_____

HOSPITAL
_____
_____
_____
_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS					
Grandmother (maternal)	Y/N	_____	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic disease

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

Frequent Sneezing
Hives
Itching
Runny Nose
Sinus Pressure

Cardiovascular

Arm Pain on Exertion
Chest Pain on Exertion
Chest Heaviness/Pressure on Exertion
Irregular Heart Beats (Palpitations)
Known Heart Murmur
Light-headed on Standing
Shortness of Breath When Lying Down
Shortness of Breath When Walking
Swelling (edema)

Constitutional

Exercise Intolerance
Fatigue
Fever
Weight Gain (____lbs)
Weight Loss (____lbs)

Eyes

Dry Eyes
Irritation
Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat

Bleeding Gums
Difficulty Hearing
Dizziness
Dry Mouth
Ear Pain
Frequent Infections
Frequent Nosebleeds
Hoarseness
Mouth Breathing
Mouth Ulcers
Nose/Sinus Problems
Ringing in Ears

Endocrine

Fatigue
Increased
Thirst/Hunger/Urination

Gastrointestinal

Abdominal Pain
Black or Tarry Stool
Blood in Stool
Change in Appetite
Frequent Indigestion
Hemorrhoids
Trouble Swallowing
Vomiting
Vomiting Blood

Genitourinary

Blood in Urine
Difficulty Urinating
Incomplete Emptying
Increased Urinary Frequency
Urinary Loss of Control

Hematologic/Lymphatic

Easy Bruising/Bleeding

HIPAA Privacy and Release of Information Authorization

Patient Name: _____

Patient ID: _____

Patient DOB: _____

I, _____hereby authorize First Choice Care and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ Date of Birth _____ Social Security Number_____

Patient
Address_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with Tennessee State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. First Choice Care uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to First Choice Care.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to First Choice Care.
3. I have the right to revoke this authorization at any time by writing to First Choice Care. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE First Choice Care TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

I authorize First Choice Care to release my medical information to the following people

Name_____ Relationship_____Phone_____

Name_____Relationship_____Phone_____

Signature of patient or representative authorized by law Date_____

_____

Relationship to Patient_____ Interpreter, if utilized_____

Witness Signature_____

Consent for Procedure/Treatment

Patient: _____ Date: _____

DOB: _____Patient ID: _____

Address: _____

I hereby voluntarily consent to outpatient care at First Choice Care, encompassing routine diagnostic procedures, examinations and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies) and administration of medications prescribed by the provider.

I further consent to those diagnostic procedures, examinations, and rendering of medical treatment by the Physician and their assistants, including nurse practitioners, physician's assistants, medical assistants, or their designees as is necessary.

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____Date: _____

Witness Signature: _____Date: _____