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

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

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal

Last Mammogram Date _____ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

Cesarean sections If yes, then number: _____

Bleeding between periods

Heavy periods

Extreme menstrual pain

Vaginal itching, burning, or discharge

Wake in the night to go to the bathroom

Hot flashes

Breast lump or nipple discharge

Painful intercourse

Sexually active

Current sexual partner is Female Male

Do you use condoms Yes No

Other Birth control method used:_____

Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

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

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.	_____	_____	_____	_____
1.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Other:_____	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade
High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level
None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine None Occasional
Moderate Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week?
__

Tobacco Do you use tobacco?
Yes No
If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

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
- Swollen Glands

Integumentary (Skin)
- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal
- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological
- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric
- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory
- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

Please add any other information about your health that you would like your provider to know here:

_____ _____

Parent, Guardian, or Caregiver Signature Date

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: _____