Family Medical Clinic
of TREZEVANT

Deborah Leggett, MSN, APRN, FNP-C
Cynthia Carroll, MSN, APRN, FNP-C, CCM
Tammy Griffis, MSN, APRN, FNP-C
Desiree Holland, MSN, APRN, FNP-C
Rhiannon Andresen, MSN, APRN, FNP-C
Makiya Rinks, MSN, APRN, FNP-C

Patient Information			
Name:	DOB:	SSN:	Martial status:
Sex:	Home phone:	Cell Phone:	Work phone:
Address:		City:	State: Zip code:
Email:			

Lives with: □ Spouse □ Alone □ Mother □ Father □ Both □Grandparent □Other

Responsible Party Information			
Mother:		Father:	
DOB:	SSN:	DOB:	SSN:
Address:		Address:	
City:	State: Zip code:	City:	State: Zip code:
Cell Ph:	Home Ph:	Cell Ph:	Home Ph:
Employer:		Employer:	
Email:		Email:	

Emergency Contact:_____ Phone:_____Relationship:_____

Insurance Information	
Primary insurance carrier:	Secondary insurance carrier:
Policy ID #:	Policy ID #:
Group #:	Group#:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:

General Consent for Care and Treatment Consent: This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatments. 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.

Assignment of Benefits- Financial Agreement: I hereby give lifetime authorization for payment of insurance benefits to be made directly to Family Medical Clinic, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize, Family Medical Clinic healthcare providers to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____Date: _____

PATIENT HISTORY

NAME: _____ DATE OF BIRTH: _____

PHARMACY: _____

MEDICATION ALLERGIES: _____

CURRENT MEDICATION: _____

_____

_____

_____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY):

___ DIABETES- DATE OF DIAGNOSIS: _____ ___ ASTHMA- DATE OF DIAGNOSIS: _____

___ ARTHRITIS- DATE OF DIAGNOSIS: _____ ___ HYPERTENSION- DATE OF DIAGNOSIS: _____

___ HIGH CHOLESTEROL- DATE OF DIAGNOSIS: _____ ___ HEART DISEASE- DATE OF DIAGNOSIS: _____

___ OSTEOPOROSIS- DATE OF DIAGNOSIS: _____ ___ PSYCHIATRIC- DATE OF DIAGNOSIS: _____

___ KIDNEY DISEASE- DATE OF DIAGNOSIS: _____ ___ KIDNEY STONES- DATE OF DIAGNOSIS: _____

___ SPASTIC COLON- DATE OF DIAGNOSIS: _____ ___ LIVER DISEASE- DATE OF DIAGNOSIS: _____

___ THYROID DISEASE- DATE OF DIAGNOSIS: _____ ____ SEIZURE DISOREDER- DATE OF DIAGNOSIS: _____

___ CHRONIC LUNG DISEASE- DATE OF DIAGNOSIS: _____ ___ NEUROLOGICAL- DATE OF DIAGNOSIS: _____

___ STOMACH PROBLEMS- DATE OF DIAGNOSIS: _____

___ CANCER- TYPE AND DATE OF DIAGNOSIS: _____

DATE OF LAST TEST:

CHOLESTEROL: _____ BLOOD PROFILE: _____ COLONOSCOPY: _____ TETANUS BOOSTER: _____

PAST VACCINATIONS (TYPE AND DATE): _____

PAST SURGICAL/ PROCEDURE HISTORY (PLEASE CHECK ALL THAT APPLY:

___ TUBAL LIGATION- DATE OF PROCEDURE: _____ ___D&C- DATE OF PROCEDURE: _____

___ HYSTERECTOMY- DATE OF PROCEDURE: _____ ___OVARY REMOVAL- DATE OF PROCEDURE: _____

___ LAPAROSCOPY- DATE OF PROCEDURE: _____ ___BACK SURGERY- DATE OF PROCEDURE: _____

___ BREAST BIOPSY-DATE OF PROCEDURE: _____ ___ BREAST REMOVAL-DATE OF PROCEDURE: _____

___ GALL BLADDER- DATE OF PROCEDURE: _____ ___ EAR TUBES- DATE OF PROCEDURE: _____

___ THYROID- DATE OF PROCEDURE: _____ ___ APPENDECTOMY- DATE OF PROCEDURE: _____

___ TONSILLECTOMY- DATE OF PROCEDURE: _____ ___ HERNIA REPAIR- DATE OF PROCEDURE: _____

___ BLADDER SURGERY- DATE OF PROCEDURE: _____ ___ BY PASS SURGERY- DATE OF PROCEDURE: _____

___ BROKEN BONES- WHICH BONES & DATE OF PROCEDURE: _____

TOBACCO USE: NO_____ YES_____ HOW MANY PACKS PER DAY? _____

ALCOHOL USE: NO_____ YES_____ HOW MANY GLASSES PER DAY? _____

STREET DRUGS: NO_____ YES _____ WHEN AND TYPE?_____

HAVE YOU EVER BEEN TREATED FOR SEXUALLY TRANSMITTED DISEASE? YES_____ NO _____

IF YES: _____GONORRHEA _____ SYPHILIS

_____ HERPES _____ CHLAMYDIA

_____ HIV _____ WARTS

DO YOU WORK? _____NO _____YES IF YES WHERE? _____

FAMILY HISTORY:

	MOTHER	FATHER	SISTER(S)	BROTHER(S)	MOTHER'S MOTHER	MOTHER'S FATHER	FATHER'S MOTHER	FATHER'S FATHER
DIABETES								
HIGH BLOOD PRESSURE								
STROKE								
HEART DISEASE								
COLON CANCER								
BREAST CANCER								
UTERINE CANCER								
OVARIAN CANCER								
LUNG CANCER								
OSTEOPOROSIS								

PREGNANCY HISTORY:

NUMBER OF TIMES PREGNANT: _____ NUMBER OF LIVING CHILDREN: _____

NUMBER OF: LIVE BIRTHS: _____ MISCARRIAGES: _____ ABORTION:_____

VAGINAL BIRTH OR CAESAREAN SECTION? _____

GYNECOLOGICAL HISTORY:

LAST MENSTRAUL CYCLE _____

DATE OF LAST PAP SMEAR: _____

HISTORY OF ABNORMAL PAP SMEAR? YES_____ NO _____

IF YES: TREATMENT: _____

BY WHOM? _____

APPROXIMATE DATE OF TREATMENT: _____

DATE OF LAST MAMMOGRAM: _____

LOCATION: _____

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Release of Information

I, _____, authorize Family Medical Clinic to contact me or any of the following listed persons regarding my medical condition. This information includes but is not limited to: appointments, tests, visit content, medications or medically necessary information. They may be informed by the following means: speaking in person, speaking over the phone, voicemail, fax, or email.

Authorized Persons:

Name:_____ Relationship_____ Phone Number_____

_____

_____

_____

_____

_____

_____

Signature:_____ Date:_____

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HIPPA Privacy and Release of Information Authorization

Patient Name: _____

Patient DOB: _____

I,_____, hereby authorize FMC of JACKSON 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 identifies my name, address, social security number, Member ID number) for the purpose of helping me resolve claims and health benefit coverage issues.

I understand that any personal health 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 law. I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if its employees or agents have taken action on the 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 to disclose 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 I may refuse to sign this authorization. Refusal to sign will not affect my eligibility for benefits or enrollment or payment coverage of services. I have been advised of this Practice Privacy Practices Release of Billing Information Policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, legal representative 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.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

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All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPPA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name:	DOB:	SSN:
Address:	Phone #:	Email:

I authorize the use and disclose of health information about me as described below:
Agency or Individual(s) Authorized to Receive my Health Information: Family Medical Clinic of Jackson

□ Prognosis Notes
□ Emergency Room Record
□ Discharge Summary
□ History & Physical
□ Consultation(s)
□ Lab
□ Pathology Reports
□ Operative Note(s)
□ Imaging/X-ray
□ X-ray reports

"Health Information" identifies you (the patient) by name and includes other demographic information about you. "Health Information" may include, but is not limited to medical records, X-ray films, slides, tracing, strips, etc.
I hereby discharge the releasing facility, its agents, and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable diseases including HIV status, and/or psychiatric diagnosis compiled during my visit, encounter or hospitalization, or make copies hereof in accordance with the policies of the facility.
□ Yes □No If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above. Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclose by the receipt and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

Patient or Authorized Personal Representative Signature Date/Time

Witness/ Clinic Staff Signature Date/Time