NEW PATIENT INFORMATION

Please Print

***PERSONAL INFORMATION**

Name _____ Social Security No. _____ Age ____
Mailing address _____ City _____ State ___ Zip _____
Telephone _____ Date of Birth _____ Sex M ___ F ___
Cell Phone No (optional) _____
Status: Single _____ Married ____ Divorced ____ Widowed ____
Occupation _____
Employer _____ Telephone _____
Address _____ City _____ State____ Zip _____

Name of Pharmacy Used _____ Phone _____
If you contact the office for a prescription to be phoned in, this is the pharmacy that will be used.

*Contact in case of an EMERGENCY (Someone who does not live with you)

Name _____ Telephone _____ Relation _____

*If the patient is a child

Mother _____ Father _____
Responsible Party _____ Relationship _____
Address (City/State/Zip) _____ Telephone _____
Individuals (other than parents) authorized to bring patient to this office for treatment:

_____

INSURANCE INFORMATION Please present insurance cards to receptionist for photocopying

*Primary Insurance _____ Policy No. _____
Address _____ Group No. _____
*Primary Card Holder's Date of Birth _____ SS # _____
*Secondary Insurance _____ Policy No. _____
Address _____ Group No. _____
Medicare No (if applicable) _____

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the payment for any professional services I receive from this clinic. I have read the above listed data and have responded to all data requested that is applicable to my Personal and Insurance information. I certify that the above information that I have provided to be true and correct to the best of my knowledge. Furthermore, I will advise you of any changes that may occur with regards to my Personal or Insurance information.

SIGNATURE _____ Date: _____

Parent/ Guardian (if minor) _____ Date: _____

PATIENT HISTORY DYERSBURG FAMILY WALK-IN CLINIC

Date: _____

Name: _____ Social Security #: _____-_____-_____

Name of Pharmacy: _____ Previous Medical Provider: _____

MEDICATIONS (prescription and regularly used over the counter meds) _____

ALLERGIES (food or medicines) _____

Are your child's immunizations up to date: Yes___ No ___

Please provide us with a copy of your child's shot record for their chart. We need it for insurance co. regulations.

Medical History

Diabetes____ Cancer ___ High Blood Pressure___ TB___ Heart Disease___ Hepatitis___ Lupus___ AIDS ____

Fibromyalgia____ Epilepsy____ Kidney Disease____ Arthritis____ Ulcer Disease____ Stroke____ Anorexia____

Chronic Fatigue____ Anemia____ Asthma____ COPD____ Acid Reflux____ Schizophrenia____ Bipolar____

Anxiety___ High Cholesterol____ ADD/ADHD____ Depression____ Thyroid Disease____ Panic Disorder____

Other Medical Problems:_____ Please note the approximate year of your diagnosis.

Hospitalizations/Surgical Procedures

Reason for Hospitalization Date Reason for Hospitalization Date

Surgeries include Tubal Ligation, C-sections, Vasectomy, Gallbladder Removal, Appendectomy, Tonsils Removed, etc.

Social History Alcohol____ Smoking____ Drug Abuse____ STD____ Chew Tobacco____

If yes to any of these, list type and/or amount per day/week if applicable_____

Family History

Diabetes____ Heart____ Cancer____ Kidney____ TB____ Asthma____ Hypertension____ Epilepsy____

Psychiatric____ Thyroid Problems____

Other_____

This includes mother, father, grandparents, brothers, and sisters.

Childhood Disease: Measles___ Mumps___ Chicken Pox___ Whooping Cough___ Scarlet Fever___

Do you have a living will completed? Yes____ No____ If yes, please provide a copy to be placed in your chart.

Pregnancies: Total____ Type of Delivery ____ (C-Section, Vaginal) Miscarriage____ Abortion____

Number of children alive at birth

Dyersburg Family Walk-In Clinic

Assignment of Benefits
&
Simple Agreement Form

The Patient authorizes Dyersburg Family Walk-In Clinic to deposit any checks received on their account, which happened to be paid in the order of the Patient's name.

In addition, the Patient authorizes Dyersburg Family Walk-In Clinic to deposit any payments received in their name from any payor who submits payment to this clinic for services they've received by Dyersburg Family Walk-In Clinic.

Patient's Name: _____ DOB: _____

SSN: _____

Signature: _____ Date: _____
(Guardian or Responsible Party)

Dyersburg Family Walk-In Clinic

PATIENT CONSENT FOR CLINIC TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, AND HEALTH CARE OPERATIONS.

PATIENT'S NAME:_____ DOB:_____
PATIENT'S SSN:_____

I understand that my health information is private and confidential. I understand that Dyersburg Family Walk-In Clinic (DFWIC) works hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that DFWIC may use and disclose my personal heath information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the DFWIC declining to treat me.

DFWIC may update this "Notice of Privacy Practice". If I ask, DFWIC will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask DFWIC to restrict how my Personal Health Information is used or disclosed to carry out treatment, payment, or health care operations. I understand that DFWIC does not have to agree to my request, I understand that DFWIC would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at anytime. If I do cancel the consent, I understand that DFWIC may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Sign and date a form that DFWIC can give me called a "Revocation of Consent for Use and Disclosure of Health Care Information'.
2. Write, sign and date a letter to DFWIC. If I write a letter it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.

I understand if I cancel this consent, DFWIC doesn't have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of DFWIC'S "Notice of Privacy Practice".

_____ _____
Patient or legally authorized individual's signature Date

_____
Relationship to patient if signed by legally authorized person

I,_____, give permission to DFWIC to release my Personal Health Information to _____.
Spouse or other authorized person

I have received copy of "Notice of Private Practices". ____Yes ____No
(circle one)

_____
Signature

If no, I do not wish to receive a copy of the "Notice of Private Practices",

_____
Signature

MEDICAL RECORDS RELEASE

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize this practice to receive a copy of my protected health information (info about me in my medical and/or financial records) as indicated below.

This information is to be disclosed to:
Dyersburg Family Walk In Clinic
2017 St John Ave, Ste B
Dyersburg, TN 38024
Phone: 731-285-6110
Fax: 731-285-6964

Description of information to be disclosed: _____

Reason for requested use of disclosure: _____

To be read & signed by patient: _____

I understand the following:

1. I may revoke this authorization at any time by presenting written notice to this practice.
2. I may not be able to revoke the authorization if the practice has already taken action involving this authorization, or if this authorization was released as a condition obtaining insurance coverage.
3. The practice will not condition treatment or payment based on my signing this authorization.
4. I am signing this authorization voluntarily.
5. No one has pressured me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
7. I acknowledge that I have had an opportunity to review this authorization understand the content and the use.
8. I have received a copy of this authorization (only if requested).

Patient Signature: _____ Date: _____

Signature of Patient's Representative: _____
(If patient is a child or unable to sign)

Relationship: _____

Expiration date of this Medical Record Release: 12 months from date of signature

Financial Agreement
Dyersburg Family Walk-In Clinic

The undersigned respectively agrees that in consideration of the services being rendered, payment of the account is guaranteed by the undersigned. The undersigned does understand that the obligation to pay the bill is the responsibility of the undersigned regardless of what insurance may or may not pay. The undersigned further agrees in the case of default of payment, and if this account should be turned over to a collection agency or an attorney for collection, all collection fees, attorney fees, costs, and other expenses will be paid by the undersigned.

Guarantor's Signature _____

Date: _____