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: _____ Telephone: _____
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 Care Holder's Date of Birth: _____ Social Security No. _____
*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 REELFOOT FAMILY WALK-IN CLINIC

Date: _____
Name: _____ Social Security Number: _____
Name of Pharmacy: _____ Previous Medical Provider: _____

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

ALERGIES (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.

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:_____

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 Diseases: 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: ____

Reelfoot Family Walk-In Clinic

Assignment of Benefits
&
Simple Agreement Form

The patient authorizes Reelfoot 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 Reelfoot Family Walk-In Clinic to deposit any payments received in their name from any payer who submits payment to this clinic for services they have received by Reelfoot Family Walk-In Clinic.

Patient's Name: _____ DOB:_____

Social Security Number:_____

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

Reelfoot Family Walk-In Clinic

PATIENT CONSENT FOR CLINIC TO USE OR DISCLOSE HEALTHCARE INFORAMTION FOR TREATMENT AND HEALTHCARE OPERATIONS

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

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

I understand that signing this document means that RFWIC may use and disclose my personal health 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 RFWIC declining to treat me.

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

Under the terms of this consent, I can as RFWIC to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that RFWIC does not have to agree to my request; I understand that RFWIC would follow agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel this consent, I understand that RFWIC may have already used or disclosed information about me and canceling this consent would not affect 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 RFWIC can give me called a "Revocation of Consent or Use and Disclosure of Health Care Information".
2.) Write, sign, and date a letter to RFWIC. If I write a letter it must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations.

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

My signature below indicates that I have been given the chance to review a current copy of the RFWIC's "Notice of Privacy Practices".

_____ _____
(Patient or legally authorized individual's signature) Date

_____
(Relationship to patient if signed by legally authorized person)

I, _____, give permission to RFWIC to release my personal health information to _____.
(Spouse or other authorized person)

I have received a copy of "Notice of Private Practices". _____Yes _____No
(Check one)

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

_____
Signature

MEDICAL RECORDS RELEASE

Patient's Name: _____

Patient Address: _____

_____

Date of Birth: _____ Social Security Number: _____

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

This information is to be disclosed to:
Reelfoot Family Walk-In Clinic
1509 E. Reelfoot Ave.
Union City, TN. 38261
Phone: (731) 886-8662
Fax: (731) 599-4382

Description of information to be disclosed: _____

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 this authorization if the practice has already taken action involving this authorization, or if this authorization was released as a condition obtaining insurance coverage.
3.) This practice will not condition treatment or payment based on 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 and 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 Represenative: _____
(If patient is a child or unable to sign)

Relationship: _____

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

Financial Agreement

Reelfoot 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: _____