PATIENT INFORMATION

NAME_____ AGE_____DATE OF BIRTH_____

MAILING ADDRESS_____HOME PHONE_____

CITY & STATE_____ZIP CODE_____

MARITAL STATUS_____SOCIAL SECURITY#_____

PATIENT'S EMPLOYER_____OCCUPATION_____

CELL PHONE_____BUSINESS PHONE_____

NAME OF INSURANCE CO_____

NAME OF POLICY HOLDER_____DOB_____SS#_____

SPOUSE INFORMATION

NAME_____DOB_____

EMPLOYER_____BUSINESS PHONE_____

OCCUPATION_____CELL PHONE_____

STUDENTS PLEASE COMPLETE

PARENTS NAME_____HOME PHONE_____

MAILING ADDRESS_____

CITY & STATE _____ZIP_____CELL PHONE_____

EMPLOYER_____OCCUPATION_____

EMERGENCY CONTACT_____ PHONE#_____

WHO REFERRED YOU TO THIS PRACTICE? _____

AUTHORIZATION: I authorize the release of any medical information necessary to carry out treatment, process a claim for medical necessity, health care operations, and/or to apply for benefits on my behalf on covered services rendered by Dr. Thompson, Dr. Glymph or Dr. Haskins. A "Patient Consent Disclosure" form is available upon request.

_____ I authorize communications by leaving messages on answering machines or voice mail and communication to immediate family members as necessary in the course of treatment.
_____I certify that the information I have reported with regard to my insurance coverage is correct.
_____I permit a copy of this authorization to be used in place of the original.
_____I understand and agree that (regardless of my insurance status) I am ultimately responsible for any unpaid charges on my account for any professional services rendered.
_____I certify this information as true and correct to the best of my knowledge. This authorization may be revoked if submitted in written form at any time.

DATE_____Signature_____

HISTORY AND PHYSICAL

Name: _____ Date: _____

Date of Birth: _____ Home #: _____ Cell #: _____

Social Security #: _____ Address: _____

Employer: _____ Work #: _____

Marital Status: Married Single Divorced Legally Separated Widowed

DRUG ALLERGIES

_____

_____

_____

Medications

_____

_____

_____

Hospitalizations or Surgery(s)

Date: _____ Reason: _____ Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Medical History

Do you drink alcohol? Yes _____ No _____ Do you use tobacco products? Yes _____ No _____

___Abdominal pain (chronic)
___Allergies/Hay fever
___Anemia/Bruise easily
___Ankles(swollen)
___Arthritis/Rheumatism
___Asthma/Wheezing
___Back pain(recurrent)
___Bone fracture/Joint pain
___Change in Bowel Habits
___Cancer
___Chest Pain
___Convulsions
___High Blood Pressure
___Diarrhea or constipation
___Diphtheria
___Diverticulitis,Crohns,Colitis
___Dizziness
___Fatigue
___Foot pain/Cold numb feet
___Gallbladder Trouble
___Hair Loss
___Headaches(frequent)
___Heart Murmur
___Hemorrhoids
___Hernia
___Sexual Dysfunction
___Indigestion or Heartburn
___Jaundice/Hepatitis
___Kidney Stones
___Leg pain(walking)
___Mental Illness
___Moodiness(excessive)
___Muscle Weakness
___Nausea/Vomiting(persistent)
___Nervousness/Depression
___Osteoporosis
___Pneumonia
___Rashes/Hives
___Menstrual Cycle Dysfunction
___Bloody Stool
___Stroke
___Tetanus
___Thyroid Disease
___Urethral Discharge
___Urination Frequency
___Painful Urination
___Blood in Urine
___Varicose Veins/Phlebitis
___Venereal Disease
___Weight Loss(recent)
___Diabetes

Charles Thompson, M.D.
Brian Glymph, M.D.
Tony Haskins, M.D.

Payment Form

Date: _____

Patient's Name: _____

Guarantor's Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone #: _____

Insurance Company Name, Address & Phone Number (If Applicable):

_____

_____

_____

I certify that the information I have provided with regard to my insurance coverage/carrier is correct. If at any time my coverage/carrier changes, I understand that it is my responsibility to update my information. If information is not updated and claims are denied due to timely filing, I understand that I will be responsible for any unpaid balance on my account. All fees and charges are to be paid at the time of service. I understand that this office will not file to Medicaid as primary or secondary insurance.

Signature of Patient/Guardian: _____

Witness: _____

We accept Cash, Check, Money Orders, Visa, Master Card & Discover.

PATIENT CONSENT DISCLOSURE
(NOTICE OF PRIVACY PRACTICES)

Federal Regulations require Patient Consent before a doctor and / or his staff in a direct treatment relationship with the patient may use or disclose Protected Health Information (PHI).

The consent signed when registration was completed says " I authorize the release of any medical information necessary to carry out treatment, process this claim, health care actions, and/or to apply for benefits on my behalf on covered services rendered by Dr. Thompson / Dr. Glymph or by his order.

This Consent may be used for any or all of the following:

**** Disclosure of information necessary to carry out treatment.***
**** Disclosure of information necessary to file for payment with insurance companies, and/or collection agencies if necessary.***
**** Disclosure of information necessary to execute other health care actions such as prescriptions or lab work sent out for processing.***
**** Communications to immediate family or recording devices necessary for treatment or collections.***

The Consent will not be used for non-routine disclosure or release of medical records to non-medical personnel outside of the payment environment. Note: Request specific to the following examples must be completed and signed prior to its release. Examples of this are:

**** Transfer of records to other doctors.***
**** Release of information to Lawyers.***
**** Release of information to Insurance Companies to evaluate your acceptance as a client by them.***
**** Letter of Medical Necessity.***

You have the right to refuse Consent to the use or disclosure of information, but such refusal may result in refusal by the doctor to treat you.
You may revoke Consent. Revocation must be in writing and will become effective upon receipt. It cannot be retroactive. The original Consent may be used to conclude any pending actions such as payment request with insurance companies.
You may restrict Consent, but it may result in refusal by the doctor to treat you if he feels that it is so restrictive that he will not be able to treat effectively.
This document shall serve as explanation of how your Consent will/will not be used for disclosure of your information.
Changes to this disclosure will be communicated by a request to sign a new disclosure at your next visit after the changes go into effect.

Patient/Guardian Signature_____**Date**_____

Dr. Thompson, M.D.
Dr. Glymph, M.D.
Dr. Haskins, M.D.

Privacy Practices Acknowledgement Form

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information may be disclosed.

I understand that due to HIPPA guidelines you are prohibited to discuss my health information with anyone other than myself.

If asked by family members, may we release information regarding your visit and test results? _____

If yes, to whom:

_____

_____

_____

_____

Signature of Patient (or Parent) Date

_____

Name of Patient

Patient Agreement

I want you to realize that your healthcare is important to myself and to this office. It is also important that you understand this is a combined effort between you the patient, myself and this office.

Any *TEST I have ordered, whether it be a lab test, a mammogram, a PAP smear, a biopsy, CAT scan, ultrasound or any other diagnostic procedure, you should receive a verbal or written report. Along with that report, you should receive an outline of the therapeutic plan and follow-up.*

It is extremely important to your health that if you do not receive such report, please without question, call my office so that we may clarify the situation. Failure to follow-up on any reports could result in significant health consequences for you.

Again, we make every effort to get these results to you but there are issues that sometimes occur. Clerical errors, change of address and lost mail can result in you not receiving your reports or follow-up plans.

I, _____, understand the concerns Dr. Thompson, Dr. Glymph & Dr. Haskins has for me to receive test results concerning my health. I agree to always follow-up on results in the event I have not been contacted. I understand that failure to obtain my reports and keep follow-up appointments could result in significant health consequences for me. I also understand annual exams are important to maintain good health.

_____ _____

Signature of patient *Date*