Carpenter Primary Healthcare (CPH)

PATIENT REGISTRATION FORM (Rev 10/13)

Please provide your insurance card and picture ID to the receptionist

Today's date:	Other Id: (*paper chart*)

PATIENT DEMOGRAPHIC INFORMATION

Last Name:	First:	Middle:	Preferred Name:
Maiden Name:	Prefix: (circle One) **Miss Mr. Mrs. Ms.**		Suffix: (circle One) **N/A I II III IV Jr. Sr.**

Date of Birth: Age: Sex: Race:

Social Security #: - - Ethnicity: Religion:

Marital Status: (circle one)

Single Married Separated Divorced Widowed Domestic Partnership Living Together Common Law Other

Drivers License State: Drivers License Number: Primary Language:

Street address:	City:	State:	ZIP Code:

Home Phone:( )	Work Phone: ( )	Mobile: ( )	Which number is best?
Messages okay?	Messages okay?	Messages okay?	Home Work Cell
Fax: ( )	Pager: ( )	E-mail:	

Pharmacy Name: **Pharmacy Phone Number:**

EMPLOYER/SCHOOL INFORMATION

Employer/School:	Status:(circle one) **FT PT FT Student PT Student Unemployed**	Occupation/Position:
Phone or Ext. ( )	Hire Date: Termination Date (if applicable)	

ASSOCIATED PARTY INFORMATION

Emergency Contact: Date of Birth : Relationship to Patient:

Street Address: City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Mobile: ( )

PARENT/GUARDIAN INFORMATION

* Please fill out below if patient is a minor*

Parent/Guardian Name: Date of Birth: Relationship to Patient:

Street Address: City: State: Zip Code:

Home Phone: Work Phone: Mobile:

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INSURANCE INFORMATION

Please understand that you are financially responsible for all charges whether or not paid by insurance.

Primary Insurance:		**Secondary Insurance:**	
Member ID:	Group Number:	Member ID:	Group Number:
Plan Name and/or Number:		Plan Name and/or Number:	
Name of Policy Holder:		Name of Policy Holder:	
Relationship to Patient: ☐ Self ☐ Spouse ☐Other		Relationship to Patient: ☐ Self ☐ Spouse ☐ Other	
If other, please describe: _____		If other, please describe: _____	

POLICY HOLDER INFORMATION

INSURANCE NAME:

Holder Name (If different from above) Social Security Number Date of Birth

Street Address City State Zip Code

Employer Occupation

Primary Phone Cell Phone Work Phone

If you have additional insurance coverage, (private/commercial), other than the TennCare Plans (OmniCare, TLC or TennCare Select), you must report this coverage immediately for proper billing of your medical care. Failure to disclose information about private/commercial insurance while receiving TennCare benefits is considered TennCare fraud and is against the law.

Determination of fraud could lead to the following:

1. Loss of TennCare benefits and possible loss of commercial insurance coverage
2. Legal proceedings by the TennCare Bureau and this office to recover the cost of uncovered medical expenses and associated costs.
3. Termination of care by this office.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

GUARDIAN / MINOR (17 AND UNDER) CONSENT

A. Patient is a minor and is _____ years of age.

- Name of Mother: _____
- Name of Father: _____

B. Patient is unable to consent because _____.

Parent or Guardian:_____ Relationship: _____ Date: _____

Witness to Signature: _____

Carpenter Primary Healthcare
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hearby authorize: _____
_____
_____

to release to: Carpenter Primary Healthcare, PLLC.
Dr. Terrell Carpenter DNP, FNP-BC
1251 Wesley Dr. Suite 104 O: (901) 348-6426
Memphis, TN 38116

Medical information relating to my treatment in the said facility for the following purpose only: _____

And the following specific type data:

[ ] Lab data	[ ] Radiologic studies	[ ] EKG and Cardiac studies
[ ] Operative reports	[ ] History & PE	[ ] Discharge data
[ ] Clinic visits	[ ] Other _____	

The expiration date or expiration event for this authorization is _____or if no expiration date is known it will expire in 6 months after date below and it covers only treatment prior to that date.I understand I may revoke this authorization at any time with a written request to the Health Information Management department of the involved offices. The request must contain the signature of the patient or the patient's legal representative and must be notarized. Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if Carpenter Primary Healthcare, PLLC. has not taken action in reliance thereon. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

Carpenter Primary Healthcare, PLLC is hereby released from any legal liability that may arise from the release of the information requested. Please note that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.

_____	_____
Signature of Patient or Authorized Individual	Date
_____	_____
Relation if Signed by Other than Patient	Phone #
_____	_____
Address City State Zip	Date of birth
_____	_____
Witness	Date

Carpenter Primary Healthcare (CPH)

SIGNATURE SECTION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my child/ward has a change in health, insurance or contact information.

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

CONSENT TO TREATMENT

I voluntarily consent to medical care at CPH encompassing routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, medical assistants, or their designees as is necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at CPH

Patient, Parent or Guardian:_____ Relationship: _____ Date: _____

If the patient is a minor or unable to consent please complete the following:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize this office to release information regarding my protected health information to include account status, test results, and scheduled appointments and information regarding my health care to the persons listed below. Any person not listed will not be able to obtain any information whatsoever. (You do not need to list other physicians or insurance companies)

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient, Parent of Guardian Signature: _____ Relationship: _____ Date : _____

PRIVACY STATEMENT

We consider any information that concerns your health, health care or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient, Parent or Guardian: _____ Relationship: _____ Date: _____

BENEFIT AUTHORIZATION

(a) I authorize CPH to release medical information to third party insurance carriers for the purpose of filing insurance claimns related to my medical care.

(b) I also request that payments of authorized benefits be made to me or on my behalf to CPH for services rendered.

(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

(d) I authorize the use of my signature on all insurance submissions.

(e) I understand I am responsible for payment of all medical expenses incurred due to services rendered.

(f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff of changes.

Patient, Parent or Guardian: _____ Relationship: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES

I authorize CPH to leave messages regarding pending appointments/or tests at the numbers indicated below. Please check all that apply:

☐ Home Phone ☐ Mobile Phone ☐ Work Phone

Patient, Parent or Guardian: _____ Relationship: _____ Date: _____

PHOTO AUTHORIZATION

I authorize CPH to use my photo as part of my protected health record for identification and treatment purposes only.

Patient, Parent or Guardian: _____ Relationship: _____ Date: _____

NO SHOW/ CANCELLATION POLICY

Please call 24 hours in advance to cancel or reschedule your appointment. If you do not call, you will be considered a "No Show" and will be charged a $50 fee. Your insurance will not cover this therefore you will be responsible for payment.

Patient, Parent or Guardian Signature: _____ Relationship: _____ Date: _____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service.
If my plan requires a referral, I must obtain it prior to my visit.
In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Carpenter Primary Healthcare on my behalf for any services furnished to me by the providers.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Carpenter Primary Healthcare

Initial Adult History Questionnaire

Today's Date: _____ Patient Name: _____ DOB: _____

How did you hear about our office? _____

Please list any specialists you are currently seeing: _____

_____

Reason for today's visit: _____

Do you have a medical advance directive or a living will? ❒ Yes ❒ No (If yes, please provide our office with a copy.)

Do you need any of the following: (Please circle)

Disability Paperwork Return to work note Surgical Clearance Prescription Refills Beside Commode Rolling Walker Cane

Are you interested in any of the following? (Please Circle)

Weight Loss HIV screening Diabetes screening Preventing pregnancy STD screening Cervical Cancer Vaccine Shingles Vaccine

Past Medical History

Abnormal Heart Rhythm	❒ Currently ❒ Past	Joint Pain (specify)_____	❒ Currently ❒ Past
Asthma	❒ Currently ❒ Past	Kidney Disease	❒ Currently ❒ Past
Back Pain	❒ Currently ❒ Past	Liver Disease	❒ Currently ❒ Past
Bipolar Disorder	❒ Currently ❒ Past	Lupus	❒ Currently ❒ Past
Cancer Specify: _____	❒ Currently ❒ Past	Neuropathy	❒ Currently ❒ Past
Congestive Heart Failure	❒ Currently ❒ Past	Sarcoidosis	❒ Currently ❒ Past
Depression	❒ Currently ❒ Past	Stomach Ulcers	❒ Currently ❒ Past
Diabetes	❒ Currently ❒ Past	Stroke	❒ Currently ❒ Past
Emphysema	❒ Currently ❒ Past	Other: _____	❒ Currently ❒ Past
Fibromyalgia	❒ Currently ❒ Past	Other: _____	❒ Currently ❒ Past
Heart Attack or blockages	❒ Currently ❒ Past		
High Blood Pressure	❒ Currently ❒ Past		
High Cholestrol	❒ Currently ❒ Past		
HIV	❒ Currently ❒ Past		

Family History

Please use the following key: MGM- Maternal Grandmother, PGM- Paternal Grandmother, MGF- Maternal Grandfather, PGF- Paternal Grandfather, M-Mother, F-Father, A- Aunt , U- Uncle, B-Brother, S- Sister, C- Cousin

Heart attack	❒ Yes ❒ No	Who _____	Comments _____
Congestive Heart Failure	❒ Yes ❒ No	Who _____	Comments _____
Diabetes	❒ Yes ❒ No	Who _____	Comments _____
Dialysis for Kidney Disease	❒ Yes ❒ No	Who _____	Comments _____
Cancer, (Type): _____	❒ Yes ❒ No	Who _____	Comments _____
Hypertension	❒ Yes ❒ No	Who _____	Comments _____

Additional Family History: _____

_____

Social History

What is your occupation? _____

Do you have a significant other? ❒ Yes ❒ No Marital Status: _____

Do you have any children? ❒ Yes ❒ No If yes, how many? _____

Have you ever used tobacco? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never

If yes: Packs per day_____ How many years?_____

Do you drink alcohol? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never

If yes, what do you drink? _____ How much? _____ How often? _____

Have you ever done drugs? ❒ Currently ❒ Formerly ❒ Occasionally ❒ Never

If yes, please specify drug and length of use: _____

Carpenter Primary Healthcare

Reproductive History (Women Only)

Do you have regular monthly periods? ❒ Yes ❒ No

Number of days in cycle? _____

Heavy Bleeding? ❒ Yes ❒ No Painful? ❒ Yes ❒ No

What age did you start having periods? _____

What age did you stop having periods? _____ Reason: _____

Have you ever been pregnant? ❒ Yes ❒ No Number of pregnancies? _____ Complications? _____

Past Surgical History

Please check any surgeries you have had:

❒ Amputation , Please specify: _____ Date: _____

❒ Appendix Removed Date: _____

❒ Back Surgery Please specify: _____ Date: _____

❒ Gallbladder Removed Date: _____

❒ Heart Bypass/ Stent Date: _____

❒ Hysterectomy - ❒ Partial or ❒ Total Reason? _____ Date: _____

❒ Mastectomy Date: _____

❒ Tonsillectomy Date: _____

Please list and other surgeries with details:

_____

_____

_____

Medication

Name of Medication	Dose	Number of times per day	Name of Medication	Dose	Number of times per day

Medication Allergies- Please list name of medication and type of reaction: _____

_____

Other Allergies- Please list name and type of reaction: _____

Preventative Care

Name of test	Date done	Results	Ordering Doctor
Pap Smear			
Mammogram			
Prostate Blood Test			
Stool Cards			
Colonoscopy			
Pneumonia Vaccine			
Tetanus Vaccine			