Lakeside North Family Medicine

38 Rowe Drive • Guntersville, AL 35976
P: (256) 571-8460 F: (256) 571-8464

Patient Name: (Last) (First) (Middle)

Date of Birth: Sex: ☐ M ☐ F Race: Ethnicity: Marital Status:

Address: City: State: Zip Code:

SSN#: Home Phone: Cell: Work:

Email Address: Preferred Communication:

Emergency Contact: Phone Number: Relationship:

Employer: Employer Phone: Occupation:

Insurance Carrier: Policy#: Group #:

IF MINOR

Father's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

Mother's Name: Date of Birth:

Address: City: State: Zip Code:

Employer: Employer Phone:

PRIVACY COMPLIANCE

Please list the family members or persons, if any, we may inform about your general medical condition and your diagnosis's which might include medical history, treatment, lab reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease and billing inquiries.

Name: Relationship: Phone:

Name: Relationship: Phone:

CAN CONFIDENTIAL MESSAGES BE LEFT ON HOME OR CELL VOICEMAIL? ☐ **Yes** ☐ **No**

I hereby authorize Lakeside North to furnish to my primary physician and insurance company(s) all information which said physician or insurance company (s) may request. I hereby assign to Lakeside North all money to which I am entitled for medical/surgical expense relative to the services rendered but not to exceed my indebtedness to the professional company. I understand that I am financially responsible for all charges, whether paid, by said insurance. I hereby waive claims of exemption under the State of Alabama. I understand There will be a $30.00 fee for returned checks. I agree to pay 27% of principal balance for collection costs should account be placed with a collection agency or attorney, plus court costs expended. I hereby give permission to Lakeside North to contact me via the numbers I have provided on issues associated with my account to include cellular numbers connected with me or my account. I understand that Lakeside North has a policy of random urine drug testing for all patients who are prescribed scheduled medications. Failure to provide a sample will disqualify me from receiving treatment at this facility. I permit a copy of this authorization to be used in place of this original.

Patient's Signature: Date:

Parent and/or Guardian's Signature: Date:

WOULD YOU LIKE A COPY OF OUR PRIVACY PRACTICES? ☐ **Yes** ☐ **No**

PATIENT MEDICAL HISTORY

Please select from the list below if you have ever been diagnosed with the following:

	Anemia		Fibromyalgia		Hypothyroidism		Vascular Problems
	Blood Clots or Free Bleeding		Gerd		Hyperthyroidism		Other
	Cancer		Glaucoma/Retinopathy		Joint Disease/Arthritis		
	Chronic Pain		Gout		Kidney Disease		
	Chronic Sinusitis		Heart Disease		Lung Disorder		
	Depression		Hepatitis		Migraine		
	Diabetes		High Blood Pressure		Seizures		
	Diverticulitis		High Cholesterol		Skin Disorders		
	Erectile Dysfunction		HIV/Aids		Stroke		

Please list any family member (father, mother, sibling, etc) that have been diagnosed with any of the conditions listed above:

Condition: Family Member:

Condition: Family Member:

DO YOU HAVE ANY ALLERGY TO ANY MEDICATION(S)? **Yes** **No** If, yes please list medications below:

TOBACCO USE: ☐Non-Smoker ☐ Current Smoker ☐Former Smoker ☐Smokeless Tobacco

ALL OF THE FOLLOWING WILL BE DOCUMENTED IN THE EMR DURING THE PATIENT'S TRIAGE PROCESS:

- **MEDICATIONS (PRESCRIBED/OVER THE COUNTER/DOSAGE AND FREQUENCY OF MEDICATION)**
- **SURGERIES/PROCEDURES/HOSPITALIZATIONS**
- **VACCINES**

Patient's Signature: Date:

Parent/Legal Guardian: Date:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: Date of Birth:

Address: City: State: Zip Code:

Phone: SSN:

Date of Request: Type of Records Requested:

PLEASE SEND MEDICAL RECORDS UPON REQUEST

I AUTHORIZE LAKESIDE NORTH TO RELEASE OR RECEIVE INFORMATION

Name of Provider/Facility:

Address: City: State: Zip Code:

Phone: Fax:

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION. INCLUDING DIAGNOSIS, TREATMENT, PROGNOSIS, ETC. OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAMER PERSON ON AND SUBSEQUENT TO THE DATE OF THE INJURIES AND/OR ILLNESS. AUTHORIZATION IS KEPT ON FILE UNLESS REVOKED IN WRITING.

Patient's Signature: Date:

Parent/Legal Guardian: Date:

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CONSENT TO TREAT

Patient Name:_____ Date of Birth: _____

I authorize the providers at Lakeside North Family Medicine to perform necessary medical examinations and tests to diagnose and treat my health conditions.

I understand that I have the right to discuss any treatment with my provider and I am encouraged to ask questions about any concerns I may have.

_____

Patient Signature Date

_____

Parent/Guardian Signature (if patient is a minor) Date