CROSSVILLE FAMILY CARE

Dr. Melissa Mayfield, DNP

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP CODE _____

GENDER _____ RACE: _____ SSN: _____ DOB _____

EMPLOYER: _____ MARITAL STATUS: _____

HOME PHONE ( ) - _____ CELL PHONE: _____ WORK PHONE: _____

RESPONSIBLE PARTY

NAME: _____ SSN: _____ DOB: _____

RELATIONSHIP: _____ PHONE #: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____ PHONE _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

____ I give permission to provider and provider's business associates to contact me via the numbers I have provided on issues associated with my account with provider to include cellular numbers connected with me or my account.

INSURANCE INFORMATION

ACCIDENT YES NO

PRIMARY INS.: _____ POLICY NO.: _____ GROUP NO.: _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INS.: _____ POLICY NO.: _____ GROUP NO.: _____

POLICY HOLDER NAME: _____ DOB: _____

PRIVACY COMPLIANCE

Please list the family or other person, if any, we may inform about your general medical condition, diagnosis, treatment, test results and/or any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease.

NAME _____ RELATION: _____ PHONE #: _____

PLEASE READ AND INITIAL THE FOLLOWING:

____ ASSIGNMENT OF BENEFITS: I hereby authorize Crossville Family Care (the center) of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to the center for charges not covered by this assignment. I also understand that the center is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier I am responsible for payment of this claim.

____ AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the center to release any information requested by my insurance company necessary to collect benefits on this claim. I further authorize any physician or institution that attended to me previously to furnish medical records or other information that may be requested by the center.

____ LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of the center, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for my health deductibles and co-insurance.

____ WORKER'S COMPENSATION: I authorize the center to furnish written reports of my treatment to any representative, attorney for, or investigator from my Worker's Compensation carrier concerning injuries sustained as a result of an employment related accident.

____ CONSENT FOR TREATMENT: I hereby give permission for all medical treatment by thy physicians and nurse practitioners at the center.

____ NOTICE OF PRIVACY PRACTICE: I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the center reserves the right to change their notice and practices and will have the information available in the office.

____ FINANCIAL AGREEMENT: I fully understand that I am ultimately responsible for any and all charges associated with my account at the center. If I fail to pay any amount due and the account is referred to a collection agency and/or attorney, I will be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

_____ _____ _____

Patient/Responsible Party Name Patient/Responsible Party Signature Date

Today's Date. _____

Patient's Legal Name: _____

MEDICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY:

- ○ AIDS/HIV
- ○ Alzheimer's
- ○ Anxiety
- ○ Asthma
- ○ Blood Clot
- ○ Cancer
- ○ Colitis / Crohn's
- ○ COPD / Emphesema
- ○ Diabetes
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Kidney Disease
- ○ Liver Disease
- ○ Pacemaker
- ○ Pain Management
- ○ Seizures
- ○ Stroke
- ○ Thyroid Disease
- ○ NONE
- ○ OTHER

OTHER:

Have you, or have you ever been under the care of a pain clinic? ○ Yes ○ No

SURGICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY. Also, please list the year.

- ○ Appendectomy
- ○ CABG
- ○ Ablation
- ○ Cardiac Stent
- ○ Gallbladder
- ○ Gastric Sleeve
- ○ Gastric Bypass
- ○ Hysterectomy
- ○ Pacemaker
- ○ Tonsil/Adenoid
- ○ Tubal Ligation

OTHER:

ALLERGIES: If you have allergies to any of the following, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Aspirin
- ○ Codeine
- ○ Hydrocodone
- ○ Lidocaine
- ○ Seasonal Allergies
- ○ LATEX
- ○ Macrolid/Azythromycin/Biaxin
- ○ Cephalosporin/Keflex/Ceftin
- ○ Fluroquinolone/Cipro/Levaquin
- ○ Penicillin/Amoxicillin
- ○ Sulfa/Bactrim/Septra
- ○ **NONE**

○ **OTHER:**

MEDICATIONS: If you take any of the following medications, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Adderall (Dextroamphetamine)
- ○ Adipex
- ○ Advair
- ○ Advil/Motrin (Ibuprofen)
- ○ Albuterol Inhaler
- ○ Ambien (Zolpidem)
- ○ Aspirin
- ○ Ativan
- ○ Benadryl
- ○ Birth Control Pills
- ○ Celexa
- ○ Cialis
- ○ Coumadin (Warfarin)
- ○ Cozaar (Lorsartan)
- ○ Digoxin (Lanoxin)
- ○ Dilantin (Phenytoin)
- ○ Glucophage (Metformin)
- ○ HCTZ
- ○ Insulin:_____
- ○ Lasix (Furosemide)
- ○ Levetra
- ○ Lexapro
- ○ Lopressor/Toprol (Metoprolol)
- ○ Lyrica (Pregabalin)
- ○ Methadone/Methadose
- ○ Naprosyn/Aleve (Naproxen)
- ○ Neurontin (Gabapentin)
- ○ Nexium (Esomeprazole)
- ○ Norco/Lortab/Vicodin
- ○ Norvasc (Amlodipine)
- ○ Percocet (Oxycodone)
- ○ Plavix (Clopidogrel)
- ○ Pravachol (Pravastatin)
- ○ Prinivil/Zestril (Lisinopril)
- ○ Potassium
- ○ Prozac
- ○ Synthroid (Levothyroxine)
- ○ Tenormin (Atenolol)
- ○ Ultram (Tramadol)
- ○ Tylenol (Acetaminophen)
- ○ Valium (Diazepam)
- ○ Wellbutrin
- ○ Xanax (Alprazolam)
- ○ Xyzal, Zyrtec
- ○ Viagra
- ○ Zocor (Simvastatin)
- ○ Zoloft
- ○ **Vitamins/Supplements** (list)

○ **OTHER:**

Today's Date: _____

Patient's Legal Name: _____

SOCIAL HISTORY: PLEASE FILL IN THE OVAL COMPLETELY to answer the following questions.

Do You Currently Use Tobacco? ○ Yes ○ No **Appoximate AGE when you started?** _____

If YES, what type do you use? ○ Smoking ○ Smokeless Vapor ○ Chewing

Packs Per Day? ○ 1 ○ 2 ○ 3 ○ 4 >

Please Select a Smoking Status:

○ NEVER smoker	○ CURRENT Sometimes Smoker	○ Current Status Unknown
○ FORMER smoker	○ LIGHT Tobacco User	○ Unknown if Ever Smoked
○ CURRENT Everyday Smoker	○ HEAVY Tobacco Use	

Do you use Alcohol? ○ Yes ○ No **Drinks per Day?** ○ 1-3 ○ 4-6 ○ 7+ ○ Occasional

Marital Status? ○ Single ○ Married ○ Divorced ○ Widowed

Number of Children? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 >

Hand Dominance? ○ Right ○ Left ○ Ambidextrious

Currently Working? ○ Yes ○ No **OCCUPATION:** _____

FEMALES ONLY: Could you be pregnant? ○ Yes ○ No **Last Menstrual Cycle?** _____

FAMILY HISTORY: PLEASE FILL IN THE OVAL COMPLETELY if you have a family member with the following:

○ Unknown / Adopted

	Father	Mother	Brother	Sister	Son	Daughter	Other
Cancer (Breast)	○	○	○	○	○	○	○
Cancer (Colon)	○	○	○	○	○	○	○
Cancer (Lung)	○	○	○	○	○	○	○
Cancer (Prostate)	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature _____ Date _____