LaFollette Family Clinic & Pediatrics

PATIENT DEMOGRAPHIC SHEET

IDENTIFICATION

Patient Name (Last)	(First)		(M.I.)
Parent or Guardian Name (Last)	(First)		(M.I.)
Mailing Address	City	State	Zip
Home Phone	Cell Phone		☐ Male ☐ Female
Date of Birth / Social Security #	☐ Married ☐ Widowed ☐ Other ☐ Single ☐ Divorced _____		
E-Mail Address	Pharmacy		

EMERGENCY CONTACT

Name (Last)	(First)	Relationship	
Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	

INSURANCE INFORMATION:

Insurance Company	Subscriber Number	Group #
Policy Holder (If different from above)	Policy Holder Date of Birth	Policy Holder Soc Sec Number

I verify that all the information above is correct to the best of my knowledge.

Patient Name: _____
(Please Print)

Patient Signature: _____

Parent or Legal Guardian Signature _____

Date Signed: _____/_____/_____

HEALTH HISTORY (Male)

Date: _____/_____/_____ **Patient Name:** _____

DOB: _____/_____/_____ **Age:** _____ **Date of last physical:** _____/_____/_____

Reason for visit: _____

_____

SURGERY		
Year	**Hospital**	**Reason for surgery**

CHECK (✓) IF YOUR FAMILY HAS OR HAD ANY OF THE FOLLOWING:

High Cholesterol:	☐ Father	☐ Mother	☐ Sister(s)	☐ Brother(s)
Heart disease/Stroke:	☐ Father	☐ Mother	☐ Sister(s)	☐ Brother(s)
Diabetes:	☐ Father	☐ Mother	☐ Sister(s)	☐ Brother(s)
High blood pressure:	☐ Father	☐ Mother	☐ Sister(s)	☐ Brother(s)
Cancer:	☐ Father	☐ Mother	☐ Sister(s)	☐ Brother(s)

Please check (✓) the following: **Mother:** ☐ Living ☐ Deceased
Father: ☐ Living ☐ Deceased

Do you smoke? ☐ Yes ☐ No **How many a day?** _____
How soon after you wake up do you smoke your first cigarette? _____
Are you ready to quit? ☐ Yes ☐ No **Thinking about it?** ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No
Alcohol use? ☐ Yes ☐ No **How much?** _____

MEDICATION LIST		
Name of Medication	**Dosage**	**Taken how often?**

Pharmacy: _____ **City:** _____

Please list all allergies:

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____/_____/_____

NAME OF PATIENT SIGNATURE DATE

LaFollette Family Clinic & Pediatrics

2425 Jacksboro Pike LaFollette TN 37766
Phone: (423) 566-4748 Fax: (423) 566-4119

PATIENT CONSENT FORM

PATIENT/MINOR CONSENT FOR TREATMENT: I authorize my permission and consent for all physicians at LaFollette Family Clinic & Pediatrics to provide medical care for myself and my family members that I designate I also grant my permission to do photo ID, diagnostic tests and procedures necessary to provide quality care to my family members and myself. I release LaFollette Family Clinic & Pediatrics and their staff from any liability for the results of above diagnostic tests and procedures.

AUTHORIZATION FOR RELASE OF INFORMATION: The LaFollette Family Clinic & Pediatrics and attending physicians are authorized to furnish any medical information requested by insurance companies or companies with whom I have coverage or public agency which may be assisting in payment of my care. I also authorize and give permission for LaFollette Family Clinic & Pediatrics to release my medical records to appropriate specialists, outside lab companies, outside x-ray companies, etc., to diagnose patients.

STATEMENT OF FINANCIAL RESPONSIBILITY: I understand that I am directly responsible to LaFollette Family Clinic & Pediatrics for all private charges for medical, lab, and surgical services rendered to me or my family, regardless of insurance coverage. In the event of default, I agree to pay all cost of collection including reasonable attorney fees. **I have read and certify that this information is correct**. I will notify you of any changes in my above status.

_____ _____

Print Patient Name **Patient Signature**

_____ **Date:** _____/_____/_____

Parent / Guardian Signature

Do you have a living will? ☐ Yes ☐ No

If you would like to find out about a "Living Will" or "Durable Power of Attorney" go to www.livingwills.com to find out how you can obtain one.

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Patient Privacy Questionnaire

1) Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results, or other healthcare information. (_____)_____
2) Can we leave a message? ☐ YES ☐ NO
3) Please list the family members or significant others, if any, whom we may inform about your medical condition. (Only in an emergency)

NAME	RELATIONSHIP	PHONE NUMBER

4) Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

NAME	RELATIONSHIP	PHONE NUMBER

Patient Name _____ Patient Signature: _____
(Please Print)

Parent / Guardian Signature: _____ Date: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

("YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT")

I have received a copy of this office's notice of privacy practices.

Name: _____ Signature: _____
(Please Print)

Parent / Guardian Signature: _____ Date: _____/_____/_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other(s) (please specify) _____

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2425 Jacksboro Pike, LaFollette TN 37766 **Phone:** (423) 566-4748 **Fax:** (423) 907-9882

Authorization to Release Medical Records/Information

Patient's Name: _____

Address: _____ **City:** _____ **ST** ____ **Zip** _____

Phone: _____ **D.O.B.:** _____ **SSN:** _____

Physician to Provide records: _____

Address: _____

Phone: _____ **Fax:** _____

Physician to Receive records: LaFollette Family Clinic & Pediatrics

Address: 2425 Jacksboro Pike LaFollette TN 37766

Phone: (423) 566-4748 **Fax:** (423) 907-9882

This request and authorization applies to:

☐ All healthcare information
☐ Healthcare information relating to the following treatment, condition, or dates of service and or treatment: _____
☐ Other

If you would like any of the following sensitive information disclosed, check the applicable boxes below:

☐ Alcohol/Drug Abuse Treatment ☐ HIV/AIDS
☐ Sexually Transmitted Diseases ☐ Mental Health
☐ Psychotherapy Notes Only (by checking this box, I am waiving any psychotherapist-patient privilege)

***Expiration or revocation of authorization** – I understand that I may revoke this authorization in writing at any time to the Medical Records Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature below.

Signature: _____ **Date:** _____

Relationship to patient (if signed by parent or guardian) _____

Witness: _____ **Date:** _____