Patient History and Review

Please fill out the following form so we may best serve your healthcare needs. This information is strictly confidential and will become part of your personal record. Please be as complete as possible.

Patient Name: _____ SSN: _____ Birthday: _____

PAST MEDICAL HISTORY :
List all past and current medical problems. Please include dates.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PAST SURGICAL HISTORY:
Please list all past surgeries and dates.
1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:
Please list all drug, food, and environmental allergies, as well as reaction.
1. _____
2. _____
3. _____
4. _____

MEDICATIONS:
Please list all prescription medications and over the counter medications, as well as vitamins, with the dosage and how often they are taken.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PHARMACY: _____

SOCIAL HISTORY:
1. Highest level of education _____
2. Have you ever smoked or used tobacco? _____
   If so, how much? _____
3. Do you drink alcohol? _____
   If so, how much? _____
4. Have you ever used illicit drugs? _____
   If so, what kind? _____
5. Marital status: M S W D
6. Occupation _____
7. Children (names/year of birth) _____
   _____
8. Spouse (name/year of birth) _____
9. Pets_____Indoor/outdoor? _____
10. Sexual preference? _____
11. Have you ever received a blood transfusion?
    _____ If yes, what year? _____
12. Date of last tetanus injection: _____
13. Have you ever had a colonscopy?_____
    If yes, when? _____
14. Females, last menstrual period: _____

FAMILY HISTORY:
Please list family members(1st degree relatives only: such as, mom ,dad, siblings,children) with a history of any of the following:
Diabetes _____
High Blood Pressure _____
Obesity _____
High cholesterol _____
Stroke _____
Heart attacks _____
Seizures _____
Thyroid problems _____
Lung problems _____
Alcoholism _____
Tuberculosis _____
Mental problems _____
Blood Disorders _____
Kidney problems _____
Skin problems _____
Cancer (what type) _____

DATE OF EXAM: _____

Adult Registration Form

Phillips Healthcare Group, PC - 6890 W. Andrew Johnson Hwy., Talbott, TN 37877 - Ph (423) 839-2120 Fax (423) 839-2125 Web: phillipshealthcaregroup.com

Name_____ Preferred Name_____ Birthdate_____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Ph _____ Cell or Other Phone _____

E-Mail Address _____ Patient Social Security # _____

Status: __ Married __ Widowed __ Single __Student __Retired __Disabled __Unemployed __ Employed

Occupation: _____ Sex: ____ Male ____ Female

Patient's Employer: _____ Employer Ph#: _____

How did you hear about us? _____

Emergency Contact: _____Relationship _____ Phone # _____

List anyone you give us permission to discuss your medical care with: _____

Financial Responsibility: ** Please complete if different from patient or if patient is a minor.**

Responsible Party Name: _____ Birthdate: _____

Address (if different from above) _____

Telephone # _____ Social Security # _____ Relationship_____

Employer: _____ Employer Ph # _____

Insurance Information: ** Please provide a copy of your insurance card(s) to our receptionist.**

Primary Insurance:	Secondary Insurance:
Insurance Co: _____	Insurance Co: _____
Name of Subscriber: _____	Name of Subscriber: _____
Birthdate of Subscriber: _____	Birthdate of Subscriber: _____
Social Security # of Subscriber: _____	Social Security # of Subscriber: _____
Patient Relationship to Insured: _____	Patient Relationship to Insured: _____

Advanced Directive for Healthcare:

I understand my right to execute a Living Will and/or Durable Power of Attorney for healthcare to assist in healthcare decisions if I become unable to make decisions.

I have a Living Will. ____Yes ____ No If yes, copy provided for chart. ____ Yes ____ No

I have granted Durable Power of Attorney. ____ Yes ____ No If yes, copy provided for chart. ____ Yes ____ No

I hereby authorize Phillips Healthcare Group, PC to disclose any information necessary for the processing of my claims related to my treatment at Phillips Healthcare Group, PC. I understand that this authorization extends to the treatment and furnishing a copy of all reports related to my treatment. The question of privacy between Phillips Healthcare Group, PC my treating physician and myself are waived with regards to the information contained in the records and reports furnished to my insurance carrier. I understand my insurance carrier may not cover and/or pay for services rendered, and I agree to be financially responsible for any services that are not covered by my insurance carrier.

Patient/Responsible Party Signature: _____ Relationship to Patient_____ Date: _____

Phillips Healthcare Group, PC

6890 W. Andrew Johnson Hwy., Talbott, TN 37877

Ph: 423-839-2120 Fax: 423-839-2125

F. Edward Phillips, Jr., MD - Lucinda Hicks, NP - Amber Moore, FNP-BC - L. Peyton Satterfield, PA-C

PATIENT AUTHORIZATION FOR DISCLOSURE

Patient Name: _____ Date of Birth: _____

*** I authorize Phillips Healthcare Group, PC to obtain information from (Ex: former physician):

_____

Name of Provider or Facility

_____

City, State, and Zip Code

_____

Phone Number and Fax Number

Description of Information for disclosure/use:

___ Entire Medical Record ___ Lab Work ___ Financial Information

___ Immunization Record ___ Radiology Results ___ Other _____

Purpose of the use or disclosure:

___ Personal Use ___ Moving ___Specialty consult (i.e. Allergist/ENT)

___ Insurance ___ Changing Doctor ___ Other _____

I understand the information disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may revoke this authorization at any time by sending a written request to the Practice Administrator. However, the revocation will not have any effect on any uses or disclosures the practice may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire one year after the date this authorization is signed. I understand that I may refuse to sign this authorization and that the practice will not condition treatment on whether or not I sign this authorization. I understand that a copy of this authorization will be provided upon patient request.

I certify that I am: ___ the patient ___ authorized representative

Signature: _____ Date: _____

If signature is not that of patient: Name: _____ Relationship to the Patient_____

Witness Signature: _____ Date: _____

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Patient Name: _____ Patient Date of Birth: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Phillips Healthcare Group, PC *Notice of Privacy Policy* and have been provided an opportunity to review it.

Initial _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I understand that Phillips Healthcare Group, PC will take all reasonable steps to ensuring my medical records are kept confidential. I give Phillips Healthcare Group, PC permission to contact me at the address(es) and phone number(s) provided to them.

Initial _____

INFECTION CONTROL

If any employee of Phillips Healthcare Group, PC or other healthcare worker is exposed to my blood or other body fluids, I hereby authorize Phillips Healthcare Group, PC to test my blood for Hepatitis B, Hepatitis C and HIV (the virus that cause AIDS). I understand the tests will be done at the expense of Phillips Healthcare Group, PC.

Initial _____

RELEASE OF CONFIDENTIAL INFORMATION FOR BILLING PURPOSES

Disclosure of substance abuse, psychiatric treatment, and HIV information is protected by federal and state law. Federal and State Law prohibit making any disclosure of confidential information without the consent of the person to whom it pertains, or as otherwise permitted or required by federal or state law. The undersigned hereby authorizes Phillips Healthcare Group, PC and affiliates and any involved physician(s) and/or employees to release to the patient's insurance company or third party payer, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding the patient's treatment for alcohol or drug abuse, the patient's treatment for mental illness, and the fact that an HIV test was performed on the patient and the patient's HIV test results.

_____ _____ _____

Signature of Patient or Authorized Representative Print Name Date

_____ _____

Witness Date