Premier Primary Care

PATIENT INFORMATION

First ______________________ Last ______________________ MI __________

Date of Birth: ______ / ______ / ______ Gender M / F Marital Status ______________

Social Security # ______________________ Email Address: ______________________

Address______________________ City ______________ State ______ Zip __________

Home # (_____)_______-_______ Cell # (_____)_______-_______ Work # (_____)_______-_______

Race _____ Asian _____ Black or African American _____ Other Race _____ White

Language: _____ English _____ Spanish _____ Other

Guardian of minor Name: ______________________ Date of Birth ______________________

Patient Employer: ______________________ Employer Phone # (_____) _______-_______

Emergency Contact Name: ______________________ Emergency Phone # (_____) _______-_______

Spouse Name: ______________________ Spouse Employer: ______________________

PHARMACY INFORMATION

Local Pharmacy Name: ______________________ City: ______________________

Mail Order Pharmacy Name (if applicable): ______________________

PRIMARY INSURANCE INFORMATION

_______ **Check if Self Pay**

Primary Insurance Name: ______________________

Secondary Insurance Name: ______________________

If policy holder of the insurance is different than the patient please complete:

Policy Holder Name: ______________________ Date of Birth __________ SSN ______________

Relationship to Patient: ______________________

Privacy Act and Medical Records Release for Insurance and Referring Physicians

I have reviewed the patient privacy act and understand that my records cannot be released without my written permission. I also authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to premier Primary Care and understand that copays/patient balances are due at the time of service. I understand that I am responsible for a No-Show Fee of $50.00 if I do not call 24 hours in advance to cancel or reschedule my appointments.

Signature of Patient or Guardian of minor ______________________ Date ______________

SEE BACK PAGE

Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Patients Name: ____ **DOB:** ____________________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
- I have reviewed the office policies and payment policies of the office of Premier Primary Care. I understand that noncompliance to the policies may result in discharge from the practice of Premier Primary Care.

I give consent to all medical care, examinations, and tests including telehealth (audio and video)

I give consent to allow patient data exchange with external hospitals and practices. **YES**____ **NO**____

In accordance with HIPAA, I wish to be contacted in the following manner:

- Cell Phone, Home Phone, Text Message, Email, Written Communication: **YES**____ **NO**____

Please list below those whom you would allow us to release test results and medical information to (i.e.: spouses, children, parents, friends):

Name/Relationship	**Phone Number**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Patient Signature ____ Date ______________________________

Guarantor Signature ____ Date ______________________________

(If under the age of 18)

Premier Primary Care

Name: ______________________ Age _____ Date of Birth _____________ Today's Date ____________

Current Medications

Please list all medications you are now taking, including those you buy without a prescription (such as cold medicine or aspirin.)
Please list name, dosage, and how many times per day they are taken.

1. ______________________ 5. ______________________ 9.______________________

2. ______________________ 6. ______________________ 10.______________________

3. ______________________ 7. ______________________ 11.______________________

4. ______________________ 8. ______________________ 12.______________________

Allergies: ______________________________________

Current Medical Problems

Please list the medical problems for which you came to see your provider for today. About when did they begin?

1. ____

2. ____

3. ____

Immunizations:

Last tetanus? __________ Zostavax (shingles)? __________ Hepatitis B? __________ Gardasil? __________

Last Tuberculin (TB) skin test? __________________ Was it _______ positive _______ negative

Have you had the chicken pox? ___ NO ___ YES At what age? ___ Have you received the Varicella vaccine? ___ What age? ___

Social:

Former Smoker ____ YES ____ NO

How many cigarettes did you smoke per day? _______ How many years did you smoke?_________

Current Smoker ____ YES ____ NO

How many cigarettes do you smoke per day? _______ How many years have you smoked? _______

Are you ready to quit? ___ YES ___ NO Do you use illegal drugs? _______ What kind? ____________

How much alcohol do you consume per day? ____ Per week? ____ Per month? ____

Do you exercise regularly? ___ YES ___ NO If yes, how many times per week? ____

Please list all past surgeries (List by date with age.) ____

____

____

Name: ______________________________ Date: ____________________

Family History Use ✔ to indicate positive history									
	Self	Father	Mother	Sister	Brothers	Grandfather	Grandmother	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depressive Disorder									
Colon/ Rectal Cancer									
Other cancer									
Diabetes									
Thyroid									
Cholesterol									

Other Physicians and Providers of Care		
Name and Specialty Provider Type	Type of Care	Date Discontinued

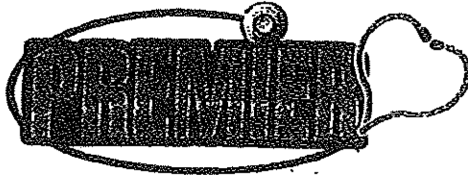
Past Tests and Procedures		
Test	Date Test Was Performed	Provider Who Performed the Test
Pap smear (Women)		
Mammogram (Women)		
PSA (Men)		
Digital Rectal Exam		
Colonoscopy		

Do you receive a flu shot yearly? ( )Yes ( )No

When was your last flu shot? ________________

Have you ever received a pneumonia shot? ( )Yes ( )No

If yes, when was your last pneumonia shot?



702 Sherrill St., Suite B Union
City, TN 38261
731-885-8884
Fax 731-599-9713
www.premierunioncity.com

Authorization to Release Medical Information

I authorize the named health care provider to **release or receive** information or records via secure fax, email or by mail.

Provider Name:	Patient Name:
Address:	SSN:
Phone:	DOB:

RECORDS AUTHORIZED TO BE RELEASED:

• Admission History and Physical	• Lab Reports
• Discharge Summaries	• Radiology Images and Reports
• Office Notes	• Psychiatric/ Mental Health Records
• Other	

This authorization will expire one year from the date of the signature below. I understand that I may revoke this authorization at any time in writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

- I am entitled to receive a copy of this authorization.

______________________________ ______________________________
Patient or Representative Date

______________________________ ______________________________
Printed Name of Representative Relationship to Patient