Cole Family Practice, LLC - Registration Form

Patient Information

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ Marital Status: M S D W SS#:_____/_____/_____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (H)_____(C)_____ (W)_____

Email address: _____

Emergency Contact: _____ Relation: _____

Phone: _____

Employer Information:

Patients Employer: _____ Occupation: _____

Address: _____

City: _____ State:_____ Zip: _____

Parent or Financially Responsible Party (if different than patient)

First: _____ Middle: _____ Last: _____

□ Male □ Female

Date of Birth: _____/_____/_____ SS#: _____/_____/_____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (H)_____ (C)_____ (W)_____

Relationship to Patient:_____

Primary Insurance

Insurance Name: _____Cardholders Relationship to Patient:_____

ID #: _____ Co-Pay Amount: _____

Secondary Insurance

Insurance Name: _____ Cardholders Relationship to Patient: _____

ID #: _____ Co-Pay Amount: _____

Please Present Insurance Cards and Picture ID at Reception Desk

Cole Family Practice
226 Jackson Meadows Drive, Hermitage, TN 37076
615-874-3422 www.colefamilypractice.org

Name _____ Date of Birth_____

Patient Medical, Surgical, Social & Family History

List Medication Allergies: _____

List all Current Medications (prescriptions, OTC, hormones, or herbal remedies)

Pharmacy (Please list name and Street):_____

Patient Health History □ No History of Illness

□ ADHD □ Autism □ Hearing Loss
□ Allergies (Seasonal) □ Heart Attack
□ Arthritis □ Heart Burn (acid reflux)
□ Asthma □ High Blood Pressure
□ Bipolar □ High Cholesterol
□ Cancer (location?_____)
□ Congestive Heart Failure □ Interstitial Cystitis
□ COPD / Emphysema □ Kidney Stones
□ Crohn's □ Mental Retardation
□ Depression / Anxiety □ Migraine Headaches
□ Diabetes □ Seizures
□ Diverticulitis □ Stomach Ulcers
□ Stroke □Fibromyalgia
□ Gout □ Hypothyroid □Hyperthyroid

Health Maintenance:

Date of last Complete Physical:_____
Date of last EKG:_____
Date of last cholesterol screen:_____
Date of last Bone Density:_____
Date of last Tetanus Injection:_____
Date of last Colonoscopy:_____
Date of last dental exam:_____

Women Only: Last Period:_____
Date of last Pap:_____Normal: Y N
Date of last Mammogram:_____
#of Preg:____ # Vag deliveries:_____
C-sec:____ # Miscar:____ # Abort:___
Menopause: Y N Year_____
Hysterectomy Y N Year_____

Other:_____
_____
_____

Patient Surgical History (List year of surgery) □ No History of Surgeries

□ Appendix Removed
□ Artificial Joints_____
□ C-Section
□ D & C
□ Ear Tubes
□ Gall Bladder Removed
□ Hernia
□ Hysterectomy (Partial / Total)
□ Mastectomy
□ Pace Maker
□ Pins or Plates inserted (location:_____)
□ Spleen Removed
□ Thyroid Removed
□ Tonsils Removed
□ Tubal Ligation

Other:_____
_____
_____

Name _____ Date of Birth_____

Family Health History

Father
List any health problems:_____

□ No Known Health Problems □ Has Died – Age and Cause of Death:_____

Mother
List any health problems:_____

□ No Known Health Problems □ Has Died – Age and Cause of Death:_____

Brothers
How many _____ □ No Known Health Problems List any health problems:_____

□ Has Died – Age and Cause of Death:_____

Sisters
How many _____ □ No Known Health Problems List any health problems:_____

□ Has Died – Age and Cause of Death:_____

Social History

Marital Status: □ Married □ Single □ Divorced □ Widowed Patients occupation _____

Alcohol use? □ No Yes- □ Beer □Liquor □Wine Average amount - _____/ Day Week Month Year

Smoke or Tobacco use? □ No □ Yes How many Packs per Day_____ Smokeless Tobacco? □ Yes □ No

Recreation Drug Use? □ No □ Yes, please list _____

Caffeine (soda, tea, coffee)? □ No □ Yes Average amount _____ / Day Week Month Year

Please describe any other information that you feel your health care provider should know:
_____
_____
_____

Name of person documenting above medical history**:** (if other than patient): _____

Do you have a living will, durable power of attorney, or advanced directives? □ Yes □ No
If No, would you like information? □ Yes □ No

OFFICE POLICY

I authorize Cole Family Practice, LLC to furnish information to insurance carriers concerning my care. I agree to pay Cole Family Practice, LLC for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

SELF-PAY PATIENTS will be required to pay for your office visit before you are seen. However, you are responsible for any additional cost related to the visit. Federal Law requires that we bill every patient the same amount. We are not allowed to change billing based on whether or not patients have insurance.

INSURANCE PATIENTS – IT IS YOUR RESPONSBILITY TO:

- Provide us with updated and current insurance information at each visit.
- Provide us with updated contact information including phone numbers and address.
- Pay your deductible and/or copay at the time of service
- Pay for any services not covered by your insurance
- Make sure you have a current referral if your insurance requires one.

As a courtesy to our patients we will file all claims with your insurance carrier and provide them with any information necessary to process the claim.

YOU ARE RESPONSBILE FOR ALL SERVICES RENDERED – IF (FOR ANY REASON) YOUR INSURANCE DOES NOT PAY- THE BALANCE IS YOUR RESPONSIBILITY.

Unpaid Bills – A collection agency will be chosen to manage delinquent accounts. Once referred to collections, no assistance will be provided by our office. If your account is placed with a collection agency, you will be responsible for all collections and attorney's fees necessary to collect this debt.

CONSENT TO TREAT & MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize Cole Family Practice practitioners to provide treatment that they may deem advisable for my dependents and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize Cole Family Practice to conduct urine drug screens as part of my assessment per the office policy. I authorize Cole Family Practice to obtain any previous medical records, for my dependents or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependents or me.

I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.

_____ _____

Patient or Responsible Party Signature **Date**

Cole Family Practice, LLC – HIPAA/Permission From

The Health Insurance Portability and Accountability Act (HIPAA) require Cole Family Practice to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, _____, authorize Cole Family Practice to

release any personal information relating to my health care

☐ To No One

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

I have reviewed the HIPAA Notice of Privacy Practices for Cole Family Practice. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: _____

Patients / Guardian Signature: _____ Date: _____