REGISTRATION FORM (please fill out COMPLETELY)

7341 Chapman Highway, Knoxville, TN 37920
865-577-9212 phone --- 866-777-2790 fax

Former PCP: Phone#

Name_____Date_____
(First, Middle and Last)

Address_____City, State, Zip_____

E-Mail Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth_____Social Security Number_____

(Circle one for each category) ***Marital Status*** **S M D W ~~** ***Gender*** **M F ~**

Race **– Black White Other Prefer not to answer**

Preferred Pharmacy_____Location_____

Emergency Contact **Relationship** **Home Phone#**
(not living at the same address)

Primary Insurance Company_____

Secondary Insurance Company_____

Please provide the front desk staff member with your insurance card to scan into your chart. If you do not have a copy, please contact your insurance company and request a copy. Please bring it with you to your next visit.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dayspring Family Care, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature_____Date_____

Name(s) of family members who are patients at Dayspring Family Care, PLLC.

INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make your own health care decisions.

You can also leave advance direction about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and are no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please feel free to ask your health provider, hospital, social worker or attorney.

It is our policy to honor our patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care decisions in order to receive care at this facility.

DO YOU HAVE A LIVING WILL?	YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY?	YES____NO____
DO YOU HAVE A DURABLE POWER OF ATTORNEY?	YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY?	YES____NO____

_____ _____

Patient Signature Date

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Consent to Treat Patient

I, _____ am presenting myself for diagnosis and treatment at Dayspring Family Care, PLLC. I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of the facilities, their medical staff or designees as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment, and I understand any special procedure or treatment involving appreciable risk will be explained to me by a provider and that I may at any time refuse such treatment.

My signature below constitutes:

1. My acknowledgement, that I have **read, understand and agree** to the foregoing.
2. That I hereby give authorization and consent.

_____ _____

Witness to Signature Signature of Patient

_____ _____

Signature of Person Signing for Patient Relationship to Patient
(if patient is a minor or unable to act on his/her own behalf)

Privacy Policy (rev.3/6/12)

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your name, address, telephone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or at work, a message will be left on your voicemail or answering machine.

As a part of our standard procedures, your prescription medication history (those medications purchased through your insurance company) will be downloaded into your chart. This will help us to avoid any problems with contraindications when prescribing medications and this information is an important part of your overall healthcare. This information will be kept in the strictest of confidence along with all of the rest of your Protected Health Information (PHI).

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

***Please note that patients may receive telephone calls regarding confidential healthcare information such as lab test results and upcoming appointments. Please indicate who may receive such information on your behalf and how you would like to receive that information. If you would like to receive lab results or reminders for upcoming appointments via e-mail, please provide us with your current e-mail address.**

√ **Check all boxes that apply.**

_____may receive information regarding my personal healthcare.
(Name) relationship (Telephone #)

_____may receive information regarding my personal healthcare.
(Name) relationship (Telephone #)

□ **Leave information on patient's home answering machine** ○ **E-mail address:**_____

□**Leave information on patient's cell phone voicemail.**

□**I choose <u>not</u> to have immunizations that I receive at Dayspring Family Care to be uploaded to the Tennessee statewide database.**

I authorize you to use or disclose my health information in the manner described above.

_____ _____
Patient Name (printed) **Date**

_____ This authorization will expire seven years after the date on which you last received services from us.
Signed Name

_____ _____
Personal Representative (printed) **Personal Representative Signture (if patient is a minor or unable to act on his/her own behalf)**

Description of Personal Representative's Authority to Act for the Patient:

Medical Records Release Authorization

7341 Chapman Highway, Knoxville, TN 37920
Phone: 865-577-9212 Fax: 866-777-2790

I authorize the use / disclosure of health information about me as described below.

Patient Name:_____Date of Birth_____SSN_____

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

Dayspring Family Care, 7341 Chapman Highway, Knoxville, TN 37920

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used.

1. I understand that this authorization will expire one year from date of signature.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Dayspring Family Care in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by Federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed name of Patient's Representative (if applicable) Relationship to Patient

Note: You have the right to know specifically what information you are authorizing for release (i.e., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information"). You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (i.e., the names of your health care provider(s)).You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

Health History Questionnaire

Surgical History		
Surgery	Date	Place

Past Medical History *(check those that apply)*		
____ Diabetes Type 2	____IV Drug Use	____Diabetes Type 1
____Hypertension	____Prescription Med Abuse	____Glaucoma
____Hyperlipidemia	____Coronary Artery Disease	____Heart Attack
____Hypothyroidism	____Seizures	____Hepatitis B
____Cancer (specify ⇨		____Hepatitis C
____Bipolar Disorder	____Stroke	____PVD
____Depression	____Allergic Rhinitis	____Suicide Attempt
____Anxiety	____Anemia	____Sexually Transmitted Disease
____Alcohol Abuse	____Asthma	____Other (specify)
MedicationAllergies *(please list medication and reaction)*		

Social History *(please circle or write your answers)*	
Occupation	
Education	8 9 10 11 grad. high school 2 year college college grad
Marital Status	Single Married Separated Divorced Widowed
Exercise Level	None Occasional Moderate Heavy
Diet	Regular Vegetarian Vegan Other (specify)
General stress level	Low Medium high
Smoking	Yes No How much per day?
Have smoked since age?	
Alcohol Intake	None Occasional Moderate Heavy
Caffeine Intake	None Occasional Moderate Heavy
Chewing Tobacco	Yes No How many times per day?
Illicit Drugs	Yes No
Guns present in the home	Yes No
Seat belts used routinely	Yes No
Sunscreen used routinely	Yes No
Smoke alarm in home	Yes No
Advance directives	Yes No
Tobacco Years of use	

Alcohol Years of use		
Sexually active?	Yes No	
Family History		
Family Member Parent, grandparents, etc….	Illness	Age at death (if deceased)
Specialty Physician(s) that you currently see for medical care		
Name	Specialty	Phone #
MEDICATIONS *(new patients only)*		
Durable Medical Equipment please list all you currently use – i.e., wheelchair, walker, oxygen, Cpap, etc….)		Where do you get your DME from?

Review of Systems

Date:_____ Name _____

In the last **six months** have you had a problem with:

Skin

Your skin?	Y / N

Endocrine

Excessive fatigue?	Y / N
Night sweats?	Y / N
Excessive thirst?	Y / N

GI

Frequent heartburn?	Y / N
Frequent indigestion?	Y / N
Abdominal pain?	Y / N
Abdominal cramps?	Y / N
Constipation?	Y / N
Bloody bowel movements?	Y / N
Black/tarry bowel movements?	Y / N
Nausea or vomiting?	Y / N
Eating?	Y / N
Swallowing?	Y / N

Cardio

Dizziness?	Y / N
Lightheadedness?	Y / N
A thumping heart?	Y / N
A racing heart?	Y / N
Chest Pains?	Y / N
Tightness across the chest?	Y / N
Unusual bruising?	Y / N

How many times have you fallen?_____

Pulmonology

Shortness of breath?	Y / N
Coughing?	Y / N

ENT

Seeing?	Y / N
Hearing?	Y / N
Smelling?	Y / N
Lumps in neck?	Y / N

Musculoskeletal

Arthritis?	Y / N
Back Pain?	Y / N
Swollen feet or ankles?	Y / N
Fluid retention in legs?	Y / N

Urinary

Frequent or painful urination?	Y / N
Uncontrolled leaking of urine?	Y / N

Constitutional?

Sleeping?	Y / N
Fever?	Y / N
Chills?	Y / N
Weight loss or gain?	Y / N

Neurological

Frequent headaches?	Y / N
Numbness or tingling?	Y / N

Do you have any other concerns that you would like to share with the provider?

_____

_____

_____