

Patient Registration Form – Spring Hill Physicians, LLC

(Please Print)

PATIENT INFORMATION

Form fields for Patient Information including Name (Last, First, Middle), Marital Status, Social Security Number, Date of Birth, E-Mail Address, Phone Numbers (Work, Cellular, Home, Pager), Address, City, State, ZIP (+4), Employment Status, Employer, Occupation, Emergency Contact Name, Relationship, and Referring Provider Name.

RESPONSIBLE PARTY INFORMATION

Form fields for Responsible Party Information including Name (Last, First, Middle), Also Known As Name, Social Security Number, Date of Birth, E-Mail Address, Phone Numbers (Work, Home), Address, City, State, ZIP (+4), Employment Status, Employer, and Employer Phone Number.

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Form fields for Primary Insurance Information including Name of Insured, Patient Relationship to Insured, Insured Employer Name, Insurance Company/Phone Number, Subscriber ID (Policy Number), Group ID, Copay Amount, Effective Date, Termination Date, Insured Date of Birth, Insured's Social Security Number, and Insurance Company Address.

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Form fields for Secondary Insurance Information including Name of Insured, Patient Relationship to Insured, Insured Employer Name, Insurance Company/Phone Number, Subscriber ID (Policy Number), Group ID, Copay Amount, Effective Date, Termination Date, Insured Date of Birth, Insured's Social Security Number, and Insurance Company Address.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

Date of last menstrual period _____
 Date of last Pap Smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications

List medications you are currently taking:

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family

| Relation | Age | State of Health | Age at Death | Cause of Death | Check (✓) if, your blood relatives had any of the following: | |
|----------|-----|-----------------|--------------|----------------|--|---------------------|
| | | | | | Disease | Relationship to you |
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay Fever | |
| Brothers | | | | | Cancer | |
| | | | | | Chemical Dependency | |
| | | | | | Diabetes | |
| | | | | | Heart Disease, Strokes | |
| Sisters | | | | | High Blood Pressure | |
| | | | | | Kidney Disease | |
| | | | | | Tuberculosis | |
| | | | | | Other | |

Hospitalizations

| Year | Hospital | Reason for Hospitalization and Outcome |
|------|----------|--|
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Pregnancies

| Year of Birth | Sex of Birth | Complications if any |
|---------------|--------------|----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Health Habits

Check (✓) which you use and how much you use.

| | | |
|--|--------------|--|
| | Caffeine | |
| | Tobacco | |
| | Street Drugs | |
| | Other | |

Occupational

Check (✓) if your work exposes you to:

| | | | |
|--|---------------|--|----------------------|
| | Stress | | Hazardous Substances |
| | Heavy Lifting | | Other |

Occupation

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates _____

| Serious Illness/Injuries | Date | Outcome |
|--------------------------|------|---------|
| | | |
| | | |
| | | |
| | | |
| | | |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date

Spring Hill Physicians
5006 Spedale Ct
Spring Hill, TN 37174
615-302-0701

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer or our Administrator in person or by phone.

I hereby agree to allow Spring Hill Physicians to leave messages at my home.

- Yes
- No

I hereby agree to allow Spring Hill Physicians to leave messages on my answering machine at work.

- Yes
- No
- Not Applicable

Spring Hill Physicians will follow HIPAA Privacy Practices when discussing your medical or billing information unless otherwise indicated with a written request for a restriction of your Protected Health Information.

Signature below is only the permission as stated above.

Date

Print Name

Signature

Relationship to patient if a minor.

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 45 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I _____

have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature

Date

Witness

AUTHORIZATION OF TREATMENT

Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center of Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these tests results to the person who is exposed to my child's body fluids.

Parent / Guardian's Signature

Relationship

Date

Spring Hill Physicians, LLC

Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Spring Hill Physicians** may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize **Spring Hill Physicians** to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Spring Hill Physicians.

ALL PATIENTS: I acknowledge that I have been given **Spring Hill Physicians** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial** _____

I, the undersigned, authorize **Spring Hill Physicians** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or responsible party) Signature

Date

Spring Hill Physicians

5006 Spedale Ct
Spring Hill, TN 37174
615-302-0701

I _____ give permission to the following person or persons to discuss or have access to my medical history/care.

Name

Date

Witness

Date