Assignment and Release

Patient Name ________________________________ **Date of Birth** ____________________

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **I authorize The Medical Group of Columbia to obtain and have access to my medication history from outside pharmacy and immunization sources.**
- **I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities.**
- **I hereby consent to treatment by my The Medical Group of Columbia providers. I authorize The Medical Group of Columbia to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general health care operations, which may include use of an electronic health information exchange.**
- **I authorize the provider to release immunizations to the Tennessee Web Immunization System.**

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any redisclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

I understand and hereby give consent for this photograph will be stored in the medical practice's electronic record as my photo identification.

By signing this consent, I, or my authorized legal representative, authorize The Medical Group of Columbia and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name of Designated person______________________________ Relationship ____________________

Name of Designated person______________________________ Relationship ____________________

How may we contact you regarding your protected health information, health status, appointments & results?

☐ Home Phone ________________ ☐ Mobile ________________ ☐ Other ____________________

☐ Email ____

May we leave a message regarding your protected health information at the numbers you provided? ☐Yes ☐No

Patient Signature ____ Date ____________________

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Revised 01.20.22

Registration Form

R. Douglas Kennedy, MD | Gavin Pinkston, MD | Gina Graves, RN FNP | Lori James, MSN FNP-BC | LeAnn Schmidt, PA-C | Brianna Seaver MSN FNP

Date: _____ / _____ / ______

Are you a new patient: ☐ Yes ☐ No

PATIENT INFORMATION (Please Print)

Last Name ______________________ First Name ______________________ M.I. ______

Birth Date ______________________ Gender ☐ M ☐ F SS# ______________________

Address ____

City ______________________ State ____________ Zip ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ____

Marital Status ☐ M ☐ S ☐ D ☐ W Spouse Name ______________________ DOB ____________

Race ☐ Alaskan Native ☐ Native American ☐ Asian ☐ African American ☐ White

Language ☐ English ☐ Spanish ☐ Other **Ethnicity** ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Preferred Pharmacy ______________ Location ______________ Phone ______________

RESPONSIBLE PARTY

Last Name ______________________ First Name ______________________ M.I. ______

Relationship to Patient ______________ Birth Date ______________ SS# ______________

Address (if different from Patient) ____

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Emergency Contact Information

Name ______________________ Relationship to Patient ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

INSURANCE INFORMATION

Primary Insurance Policy Holder (if other than patient)

Last Name ______________________ First Name ______________________ M.I. ______

Birth Date ______________________ Gender ☐ M ☐ F Employer Name ______________________

Policy Holder Relationship to Patient ____

ID/Certification No. ______________________ Policy/Group No. ______________________

Secondary Insurance Policy Holder (if other than patient)

Last Name ______________________ First Name ______________________ M.I. ______

Birth Date ______________________ Gender ☐ M ☐ F Employer Name ______________________

Policy Holder Relationship to Patient ____

ID/Certification No. ______________________ Policy/Group No. ______________________

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account (s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to Premier Radiology and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and /or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

Patient Signature ______________________________ Date ______________________

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New Patient Form

R. Douglas Kennedy, MD | Gavin Pinkston, MD | Gina Graves, RN FNP | Lori James, MSN FNP-BC | LeAnn Schmidt, PA-C | Brianna Seaver MSN FNP

Full Legal Name ______________________ **Date of Birth** ____________

The Medical Group of Columbia **Provider** ______________________ **Appointment Date** ____________

NURSING ENCOUNTER FORMS (Please Print)

Gender ☐ M ☐ F Age ____________ Which hand do you write with? ☐ Right ☐ Left

CHIEF COMPLAINT

What is your reason for seeing the Doctor? ______________________

____

HISTORY OF PRESENT ILLNESS

How long have you had symptoms? ______________________

Are symptoms getting worse, better or same? ______________________

Have you had these symptoms before? ______________________

What makes symptoms better? ______________________

What makes symptoms worse? ______________________

Have you seen another doctor for these symptoms? ☐ Yes ☐ No If yes, who? ____________

Was medication prescribed? ☐ Yes ☐ No If yes, what? ______________________

MEDICAL SPECIALISTS (other doctors, therapies, home health, medical equipment etc.)

Provider	Specialty	Last Seen

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Revised 01.20.22

Medication List

Full Legal Name ______________________________ **Date of Birth** ____________

Preferred Pharmacy ______________ **Location** ______________ **Phone** ______________

MEDICATION ALLERGIES

Medication	Reaction	Medication	Reaction

MEDICATION LIST

Medication	Dosage (mg, mcg, ccs)	How many times each day do you take it?

THE MEDICAL GROUP OF COLUMBIA

AdvancedHEALTH

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Patient History Past Medical History

Full Legal Name ______________________________ **Date of Birth** ____________

PAST MEDICAL HISTORY

- ☐ Alcohol Abuse
- ☐ Allergy / Hay Fever
- ☐ Anemia / Low Blood Count
- ☐ Arrhythmias (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Automobile Accident with Injuries
- ☐ Bleeding Problems
- ☐ Brain Tumor
- ☐ Back Injury
- ☐ Cancer - Type ______________
- ☐ Cervical Spine Disease / Neck Problems
- ☐ Circulation Problems
- ☐ Colonic Polyps
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Use
- ☐ Hormone Abnormalities
- ☐ Emphysema / Lung Disease
- ☐ Epilepsy / Seizures
- ☐ Genital / Urinary Disease
- ☐ Head Injury
- ☐ Headache / Migraine
- ☐ Headache / Tension
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Liver Disease / Hepatitis
- ☐ Loss of Consciousness
- ☐ Lumbar Spine Disease / Low Back Pain
- ☐ Measles
- ☐ Meningitis
- ☐ Menstrual / Sexual Dysfunction
- ☐ Mumps
- ☐ Murmur
- ☐ Neck Injury
- ☐ Neuromuscular (disease of muscles)
- ☐ Nerve Damage (disease of nerves)
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Renal / Kidney Disease
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Smoking
- ☐ Spinal Cord Injury
- ☐ Stroke (symptoms: ______________)
- ☐ Thyroid Disease

Please list any other conditions for which you have been treated: ______________________________

____

PREVENTATIVE MEDICAL HISTORY (give date of last)

Test	Date
Colonoscopy	
Mammogram	
Bone Density	
Eye Exam	
Pap smear (women only)	

Vaccination	Date

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Patient History Surgical

Full Legal Name ______________________________ **Date of Birth** ______________

SURGICAL HISTORY

SURGERY	DATE	SURGEON	PLACE
Appendectomy / Appendicitis			
Amputation			
Arthroscopy / Knee Surgery			
Brain Aneurysm			
Brain Surgery			
Cardiac Bypass / Open Heart Surgery			
Carotidendarterectomy (artery in the neck)			
Cataract / Eye Surgery			
Cesarean Section			
Cholecystectomy / Gall Bladder			
Hemorrhoidectomy			
Hernia Repair (Groin/Stomach/Belly)			
Hysterectomy			
Laparoscopy (Abdomen)			
Mastectomy (Breast Surgery)			
Neck Surgery			
Pacemaker Installed			
Prostate Surgery			
Tonsillectomy			
Tubal Ligation			
Ulcer			
Vasectomy			
Other			

Please list any other information that you feel is relevant to your doctor visit today:

Patient History Family/Social

Full Legal Name ______________________________ **Date of Birth** ______________

FAMILY HISTORY

Please Check Appropriate Answer

Mother Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Father Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Brothers Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Sisters Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No

If any of your immediate family is deceased, please give age and cause of death.

List any disease or illnesses that run in your family.

Does anyone in your family have any of the following conditions?
If so check the box and list the family member (mother, father, sister, brother, etc.)

☐ Arthritis ______________
☐ Bleeding Disorder ______________
☐ Brain Aneurysm ______________
☐ Brain Tumor ______________
☐ Cancer ______________
☐ Diabetes ______________
☐ Dementia ______________
☐ Epilepsy ______________
☐ Heart Disease ______________
☐ High Blood Pressure ______________
☐ Kidney Disease ______________
☐ Migraine / Headache ______________
☐ Numb Hands or Feet ______________
☐ Stroke ______________
☐ Thyroid Disease ______________
☐ Other ______________

SOCIAL HISTORY

Are you a smoker? ☐ Yes ☐ No How many packs a day? ________ How long have you smoked? ________

Have you ever smoked? ☐ Yes ☐ No For how long? ________ When did you quit? ________

Do you drink alcohol? ☐ Yes ☐ No How much? ________ How often? ________ Type? ________

Have you used street drugs? ☐ Yes ☐ No If yes, what type? ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ IV Drugs

Do you still use street drugs? ☐ Yes ☐ No If yes, how often? ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How far did you go in school? ________ Occupation / Job? ________

Number of children? ________ Who lives in your household? ________

Do you have difficulty with ☐ Preparing meals ☐ Bathing ☐ Dressing / Grooming ☐ Tolieting

SEXUAL HISTORY

Have you been sexually active in the last 12 months? ☐ Yes ☐ No Type of contraception ________

WOMEN ONLY: Date of last menstrual period? ________ Are you pregnant? ☐ Yes ☐ No

Number of Pregnancies ________ Births ________

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Patient History Review of Systems

Full Legal Name ______________________________ **Date of Birth** ____________

REVIEW OF SYSTEMS

Yes No

☐ ☐ **General Symptoms**
Fever chills, headache, loss of appetite Weight loss or weight gain

☐ ☐ **Eyes**
Blurred or double vision, eye pain, blindness

☐ ☐ **Ear, Nose, Throat, Mouth**
Ear infection, sore throat, sinus problem vertigo/spinning sensation; problems with taste or smell

☐ ☐ **Respiratory**
Wheezing, cough, shortness of breath, Coughing up blood or sputum

☐ ☐ **Cardiovascular**
Chest pains, heart murmurs, racing heart, irregular rhythm

☐ ☐ **Gastrointestinal**
Constipation, stomach pain, nausea, diarrhea, vomiting

☐ ☐ **Bladder / Urinary Tract**
Cancer, stones, recurrent infections

☐ ☐ **Musculoskeletal**
Arthritis, joint pain, back pain, muscle pain, cramps

☐ ☐ **Skin**
Rash, itching, boils, dry skin, oily skin, changes in moles

☐ ☐ **Neurologic**
Seizures, numbness, tingling, dizziness, stroke, weakness, fainting, loss of vision, inability to speak

☐ ☐ **Psychologic**
Depression, anxiety, memory problems

☐ ☐ **Endocrine**
Tired, excess thirst, too hot / cold

☐ ☐ **Hematologic / Lymphatic**
Bleeding problems, swollen glands

☐ ☐ **Allergic / Immunologic**
Seasonal allergies, AIDS

☐ ☐ **Sleep**
Snoring, increased daytime sleepiness, difficulty falling asleep, difficulty staying asleep, falling asleep while driving, frequent daytime naps

☐ ☐ **Walking**
Shuffling, small steps, off-balance staggering, stumbling, tripping walking on outside of feet, problems getting up from chair or out of bed

Explain any Yes answers:

Please list any other information that you feel is relevant to your doctor visit today:

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