**PATIENT REGISTRATION**

**Name** (F-M-L)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_\_\_\_\_\_  **Sex:** Male Female

**Mother’s Full & Maiden Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mother’s Social Security Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father’s Full Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father’s Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father’s Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Father’s Social Security Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Person (if not patient)**

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance**

**Tenncare (if Applicable)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicare Number** **(if Applicable)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Company Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Company Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release (Information and Assignment of Benefit)**

**Family Health Care of Camden**

**Steven L. Cannady, F.N.P.**

**350 Hospital Drive ● Camden, TN 38320**

**731-584-3330**

|  |
| --- |
| **Signature of File** |

**I authorize use of this form on all my insurance submissions past, present, and future. I authorize release of information to all my Insurance Companies. I understand that I am responsible for my bill. I authorize my Doctor/F.N.P. to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment directly to my Doctor/F.N.P. I permit a copy of this authorization to be used in place of the original.**

**SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HEALTH CARE OF CAMDEN

STEVEN L. CANNADY, FNP

VIRGINIA M PEEBLES, FNP

350 Hospital Drive, Camden, TN 38320

APPOINTMENT POLICY

Appointments in our office are valuable to you, the patient, as well as to us, the service provider. Because of this, we ask that our patients please try to give our office a 24 hour notice if they must miss an appointment, so that we may be able to allow someone else to be treated at that time slot. We realize, however, that sometimes events arise that may not allow you to call to cancel your appointment. In that event we will be happy to reschedule your appointment. However, after 3 missed appointments, our office reserves the right not to reschedule further visits.

Also, in the event you are later for you appointment, we reserve the right to reschedule that appointment.

I have read and understand the above statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature Date

FAMILY HEALTH CARE OF CAMDEN

STEVEN L. CANNADY, FNP

VIRGINIA M. PEEBLES, FNP

350 Hospital Drive, Camden, TN 38320

FINANCIAL AGREEMENT

I hereby accept responsibility for charges not covered by my Insurance Carrier or for all charges rendered to me if I do not have insurance coverage. By signing below, I also accept responsibility for reasonable attorney’s fees, court costs and/or any collection fees that may be incurred in the event it becomes necessary to collect monies owed by me to Family Health Care of Camden.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Receipt

 Family Health Care’s Notice of Privacy Practices

This certifies that I have reviewed a copy of Family Health Care’s Notice of Privacy Practices.

I understand that it explains the uses and disclosures that may be made with my protected health information.

I understand my privacy rights as a patient of Family Health Care.

I authorize Family Health Care to discuss any of my test results and medical condition with the following persons:

 Name Relationship to patient

 (Example: spouse, son, daughter, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Health Care of Camden

Steven L Cannady, FNP Virginia M. Peebles, FNP

731-584-3330

350 Hospital Drive

Camden, TN 38320

**General Consent for Care and Treatment Consent**

**TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).**

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Patient Name (Please Print) Date

Patient or Guardian Signature Relationship to Patient

Signature of Witness Date

**HOPITALIZATIONS OR SERIOUS ILLNESSES**

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **HOPITALIZATION OR ILLNESS** | **HOSPITAL/PHYSICIAN’S NAME** | **CITY, STATE** |
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| **MEDICATIONS** |
| **DATE** | **MEDICATION/STRENGTH** | **FREQUENCY** | **CONDITION** |
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| **ALLERGIES** |
| **PLEASE LIST ALLERGIES, SENSITIVITIES, AND/OR REACTIONS TO ANY MEDICATIONS** |
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**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child’s health. It is my responsibility to inform the office of any changes in my child’s medical status. I also authorize the healthcare staff to perform necessary services that my child may need.**

**Parent/Guardians Signature**

**Date**

**PCP’s Review**

**PCP’s Signature**

**HEALTH HISTORY**

**Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_**

**PERSONAL INFORMATION**

**Please check any problems your child currently has or ever has had.**

**Thumb Sucking 🞎Yes 🞎 No Dental Problems? 🞎 Yes 🞎 No Was/Is child 🞎 breast or 🞎bottle fed?**

**Toilet Training Problems 🞎 Yes 🞎 No Bed Wetting? 🞎 Yes 🞎 No Age stopped\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diarrhea or Constipation 🞎 Yes 🞎 No Eye Problems? 🞎 Yes 🞎 No Due Date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Irritable/Temper Problem 🞎 Yes 🞎 No Speech Problems? 🞎 Yes 🞎 No Child’s Birth Weight\_\_\_\_\_\_Lbs.\_\_\_\_\_\_\_Oz**

**Nightmares/Sleep Problems 🞎 Yes 🞎 No Hearing Problems? 🞎 Yes 🞎 No Delivery 🞎Vaginal 🞎C-Section**

**Feeding or Eating Problems 🞎 Yes 🞎 No Emotional Problems 🞎 Yes 🞎 No Complications? 🞎 Yes 🞎 No**

**# Meals each Day\_\_\_\_ # of Snacks\_\_\_\_\_ Discipline Problems 🞎 Yes 🞎 No**

**Does your child take vitamins, fluoride, Developmental Problems 🞎 Yes 🞎 No**

**Iron or other supplements 🞎 Yes 🞎 No Alcohol/Drug use? 🞎 Yes 🞎 No**

**Is your water fluoridated? 🞎 Yes 🞎 No Is your child doing well in school? 🞎 Yes 🞎 No**

**Did the mother use any cigarettes, alcohol, Does your child get along well with other children? 🞎 Yes 🞎 No**

**drugs, or medications during pregnancy? 🞎 Yes 🞎 No Has your child ever eaten dirt, paint, or plaster? 🞎 Yes 🞎 No**

**HEALTH INFORMATION**

**Has your child ever had?**

**Mumps/Measles 🞎 Yes 🞎 No Croup 🞎 Yes 🞎 No Frequent Ear Infections 🞎 Yes 🞎 No**

**Chicken Pox 🞎 Yes 🞎 No TB/Lung Disease 🞎 Yes 🞎 No Frequent Colds 🞎 Yes 🞎 No**

**Eczema/Skin Problems🞎 Yes 🞎 No High Blood Pressure 🞎 Yes 🞎 No Convulsions/Epilepsy 🞎 Yes 🞎 No**

**Pneumonia 🞎 Yes 🞎 No Heart Murmur 🞎 Yes 🞎 No Congenital Heart Defects 🞎 Yes 🞎 No**

**Asthma/Wheezing 🞎 Yes 🞎 No STD’s 🞎 Yes 🞎 No Hemophilia 🞎 Yes 🞎 No**

**Cancer 🞎 Yes 🞎 No High Cholesterol 🞎 Yes 🞎 No Handicaps/Disabilities 🞎 Yes 🞎 No**

**Hepatitis 🞎 Yes 🞎 No Diabetes 🞎 Yes 🞎 No Rheumatic Fever 🞎 Yes 🞎 No**

**Aids 🞎 Yes 🞎 No Allergies 🞎 Yes 🞎No Abnormal Bleeding 🞎 Yes 🞎 No**

**Emotional Disorders 🞎 Yes 🞎 Suicide Attempts 🞎 Yes 🞎 No No Kidney/Bladder Problems 🞎 Yes 🞎 No**

**Please list any medical conditions your child has that has not been addressed above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHARMACY: Phone:**

**FAMILY HISTORY**

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| --- |
| **Fill in health information about your family ALL INFORMATION IS STRICTLY CONFIDENTIAL** |
| **RELATION** | **AGE** | **STATE OF HEALTH** | **AGE AT DEATH** | **CAUSE OF DEATH** | **CHECK** (√) if your blood relatives had any of the following: **DISEASE RELATIONSHIP**  |
| **FATHER** |  |  |  |  |  | **Arthritis, Gout** |  |
| **MOTHER** |  |  |  |  |  | **Asthma, Hay Fever** |  |
| **BROTHERS** |  |  |  |  |  | **Cancer** |  |
|  |  |  |  |  |  | **Chemical Dependency** |  |
|  |  |  |  |  |  | **Diabetes** |  |
|  |  |  |  |  |  | **Heart Disease, Strokes** |  |
| **SISTERS** |  |  |  |  |  | **High Blood Pressure** |  |
|  |  |  |  |  |  | **Kidney Disease** |  |
|  |  |  |  |  |  | **Tuberculosis** |  |
|  |  |  |  |  |  | **Other** |  |
| **HOSPITALZATION** |
| **YEAR** | **HOSPITAL** | **REASON** | **OUTCOME** |
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|  |  |  |  |
| **HAVE YOU EVER HAD A BLOOD TRANSFUSION** | 🞎 YES 🞎 NO | **DATE:** |
| **SERIOUS ILLNESS/INJURIES** | **DATE** | **OUTCOME** |
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**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**