**PATIENT REGISTRATION**

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

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

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

**Email Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Maiden Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** Single Married Widow Divorced **Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employment Status\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Telephone**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Employer/Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Emergency Contact DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Person (if not patient)**

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

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

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

**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**

**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

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

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

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

**HEALTH HISTORY**

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

**Age\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your reason for visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **SYMPTOMS** Check **(**√) symptoms you currently have or had in the past year. |
| **GENERAL** | **GASTROINTESTINAL** | 🞎 Crossed Eyes | 🞎 Other |
| 🞎 Chills | 🞎 Appetite poor | 🞎 Difficulty Swallowing | **WOMEN ONLY** |
| 🞎 Depression | 🞎 Bloating | 🞎 Double Vision | 🞎 Abnormal Pap Smear |
| 🞎 Dizziness | 🞎 Bowel Changes | 🞎 Earache | 🞎 Bleeding between periods |
| 🞎 Fainting | 🞎 Constipation | 🞎 Ear Discharge | 🞎 Breast Lump |
| 🞎 Fever | 🞎 Diarrhea | 🞎 Hay Fever | 🞎 Extreme Menstrual Pain |
| 🞎 Forgetfulness | 🞎 Excessive Hunger | 🞎 Hoarseness | 🞎 Hot Flashes |
| 🞎 Headache | 🞎 Excessive Thirst | 🞎Loss of Hearing | 🞎 Nipple Discharge |
| 🞎 Loss of Sleep | 🞎 Gas | 🞎 Nosebleeds | 🞎 Painful Intercourse |
| 🞎 Loss of Weight | 🞎 Hemorrhoids | 🞎 Persistent Cough | 🞎 Vaginal Discharge |
| 🞎 Nervousness | 🞎 Indigestion | 🞎 Ringing in Ears | 🞎 Other |
| 🞎 Numbness | 🞎 Nausea | 🞎 Sinus Problems | Date of last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Sweats | 🞎 Rectal Bleeding | 🞎 Vision – Flashes | Date of last Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **MUSCLE/JOINT/BONE** | 🞎 Stomach Pain | 🞎 Vision – Halos | Have you had a mammogram? YES NO |
| Pain, weakness, numbness in: | 🞎 Vomiting | **SKIN** | Are you Pregnant? YES NO |
| 🞎 Arms  | 🞎 Vomiting Blood | 🞎 Bruise Easily | Number of children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞎 Back | **CARDIOVASCULAR** | 🞎 Hives |  |
| 🞎 Feet | 🞎 Chest Pain | 🞎 Itching |  |
| 🞎 Hands | 🞎 High Blood Pressure | 🞎 Change in Moles |  |
| 🞎 Hips | 🞎 Irregular Heartbeat | 🞎 Rash |  |
| 🞎 Legs | 🞎 Low Blood Pressure | 🞎 Scars |  |
| 🞎 Neck | 🞎 Poor Circulation | 🞎 Sore that won’t heal |  |
| 🞎 Shoulders | 🞎 Rapid Heartbeat | **MEN ONLY** |  |
| **GENITO-URINARY** | 🞎 Swelling of Ankles | 🞎 Breast lump |  |
| 🞎 Blood in Urine | 🞎 Varicose Veins | 🞎 Erection Difficulties |  |
| 🞎 Frequent Urination | **EYE, EAR, NOSE, THROAT** | 🞎 Lump in Testicles |  |
| 🞎 Lack of Bladder Control | 🞎Bleeding Gums | 🞎 Penis Discharge |  |
| 🞎 Painful Urination | 🞎 Blurred Vision | 🞎 Sore on Penis |  |
| **CONDITIONS Check (√) conditions you have or have had in the past.** |
| 🞎 AIDS | 🞎 Chemical Dependency | 🞎 High Cholesterol | 🞎 Prostate Problem |
| 🞎 Alcoholism | 🞎 Chicken Pox | 🞎 HIV Positive | 🞎 Psychiatric Care |
| 🞎Anemia | 🞎 Diabetes | 🞎 Kidney Disease | 🞎 Rheumatic Fever |
| 🞎Anorexia | 🞎 Emphysema | 🞎 Liver Disease | 🞎 Scarlet Fever |
| 🞎 Appendicitis | 🞎 Epilepsy | 🞎 Measles | 🞎 Stroke |
| 🞎 Arthritis | 🞎 Glaucoma | 🞎 Migraine Headaches | 🞎 Suicide Attempt |
| 🞎 Asthma | 🞎 Goiter | 🞎 Miscarriage | 🞎 Thyroid Problems |
| 🞎 Bleeding Disorders | 🞎 Gonorrhea | 🞎 Mononucleosis | 🞎 Tonsillitis |
| 🞎 Breast Lump | 🞎 Gout | 🞎 Multiple Sclerosis | 🞎 Tuberculosis |
| 🞎 Bronchitis | 🞎 Heart Disease | 🞎 Mumps | 🞎 Typhoid Fever |
| 🞎Bulimia | 🞎 Hepatitis | 🞎 Pacemaker | 🞎 Ulcers |
| 🞎 Cancer | 🞎 Hernia  | 🞎 Pneumonia | 🞎 Vaginal Infections |
| 🞎 Cataracts | 🞎 Herpes | 🞎 Polio | 🞎 Hypertension |
| **MEDICATIONS** List medications you are currently taking. | **Allergies** To medications or substances. |
|  |  |
|  |  |
|  |  |
|  |  |
| **PHARMACY:** | **Phone:** |

**FAMILY HISTORY**

|  |
| --- |
| **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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **HAVE YOU EVER HAD A BLOOD TRANSFUSION** | 🞎 YES 🞎 NO | **DATE:** |
| **PREGNANCY HISTORY** |
| **YEAR OF BIRTH** | **SEX OF BIRTH** | **COMPLICATIONS IF ANY** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **HEALTH HABITS** | **CHECK (**√**) WHICH SUBSTANCES YOU USE AND DESCRIBE HOW MUCH YOU USE.** |
| **CAFFEINE** | **TOBACCO** | **DRUGS** | **OTHER** |  |
|  |  |  |  |  |
| **OCCUPATIONAL CONCERNS** | **CHECK (**√**) IF YOUR WORK EXPOSES YOU TO THE FOLLOWING:** |
| **STRESS** | **HAZARDOUS SUBSTANCES** | **HEAVY LIFTING** | **OTHER** | **YOUR OCCUPATION** |
|  |  |  |  |  |
| **SERIOUS ILLNESS/INJURIES** | **DATE** | **OUTCOME** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**For Patients Over Age 18**

**Do you have a living will or durable power of attorney? Yes\_\_\_\_\_ No\_\_\_\_\_**

**Was a copy provided? Yes\_\_\_\_\_ No\_\_\_\_\_**

**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.**

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

**Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**