the GROVE Primary Care Clinic, LLC.

NEW PATIENT FORMS

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	PREVIOUS NAME (IF APPLICABLE):

MAILING ADDRESS:

CITY / STATE / ZIP:

HOME PH:	CELL PH:	WORK PH:

DATE OF BIRTH:	SEX: ☐ MALE ☐ FEMALE	SOCIAL SECURITY #:	MARITAL STATUS:

EMERGENCY CONTACT NAME:	EMERGENCY CONTACT #:	REALTIONSHIP TO PATIENT:

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING):

EMAIL ADDRESS:

CAN WE LEAVE MESSAGES REGARDING YOUR MEDICAL CARE/RESULTS? ☐ YES ☐ NO

RACE (PLEASE FILL OUT ALL SECTIONS BELOW)

☐ WHITE ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN
☐ HISPANIC ☐ BLACK OR AFRICAN AMERICAN ☐ OTHER
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ DECLINE

ETHNICITY (PLEASE SELECT ONE):

☐ HISPANIC
☐ NOT HISPANIC OR LATINO
☐ DECLINE

PREFERRED LANGUAGE (PLEASE SELECT ONE):

☐ ENGLISH ☐ SPANISH ☐ OTHER _____

PREFERRED PHARMACY NAME AND LOCATION:

INSURANCE INFORMATION- please provide a copy of your card

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
INSURANCE COMPANY NAME:	INSURANCE COMPANY NAME:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
GROUP/POLICY NUMBER AND SUBSCRIBER ID:	GROUP/POLICY NUMBER AND SUBSCRIBER ID:
RELATIONSHIP TO POLICY HOLDER:	RELATIONSHIP TO POLCIY HOLDER:

RESPONSIBLE PARTY- if the patient is a minor (under the age of 18), the parent or guardian will be listed as the guarantor

LAST NAME: FIRST NAME

DATE OF BIRTH:	SOCIAL SECURITY #:	PHONE:

ADDRESS OF PERSON RESPONSIBLE:

CITY / STATE / ZIP:	RELATIONSHIP TO PATIENT:

By your signature below, you understand and acknowledge that you will be responsible for the charges of any services if the charges are denied, non-covered or not paid by your insurance.

Signature of Responsible Party: _____ Date: _____

the GROVE Primary Care Clinic, LLC.

PATIENT HEALTH ASSESSMENT

NAME: _____ **DATE**: _____

AGE: _____ **SEX**: M F **DOB**: _____

PREVIOUS PROVIDER: _____ **LAST PHYSICAL**: _____

CONTACT NUMBER: _____ **OCCUPATION**: _____

Please list any hearing, vision or reading issues:

_____

Do you live alone? YES NO

Do you have frequent falls? YES NO

Please bring **ALL** your prescription medicine and over-the-counter vitamins and supplements to **ALL** appointments and list all prescriptions, over-the-counter medications, supplements and vitamins you take, including the dose and strength.

Are you allergic to latex? YES NO

ALLERGIES:_____

_____

_____

_____

IMMUNIZATIONS:

☐ Tetanus	☐ Zostavax	☐ Pheumonia
☐ Hepatitis	☐ Gardasil	☐ Chickenpox
☐ Influenza	☐ Meningicoccal	☐ MMR (measles,mumps,rubella)

PAST MEDICAL HISTORY- Do YOU have now or have you ever had any of the following

Heart Disease	YES	NO	Hepatitis	YES	NO
High Blood Pressure	YES	NO	Kidney Stones	YES	NO
Chest Pain	YES	NO	Venereal Disease/ STD	YES	NO
Blood Disease/Anemia	YES	NO	Arthritis	YES	NO
Gallbladder Disease	YES	NO	Depression	YES	NO
Thyroid Disease	YES	NO	Diabetes	YES	NO
Lung Disease	YES	NO	Stroke	YES	NO
Asthma	YES	NO	Recent Tick Bites	YES	NO
Back Disorder	YES	NO	Cancer (location)	YES	NO
Epilepsy	YES	NO	Glaucoma	YES	NO
Ulcers	YES	NO	HIV/AIDS	YES	NO
Polio	YES	NO	Chicken Pox	YES	NO
Rheumatic Fever	YES	NO	Other: _____		

the GROVE Primary Care Clinic, LLC.

PATIENT NAME: _____ **DOB:** _____

FAMILY/SOCIAL HISTORY

Do you have a family history of:			Relationship
Heart Disease	YES	NO	_____
High Blood Pressure	YES	NO	_____
Diabetes	YES	NO	_____
Stroke	YES	NO	_____
Cancer	YES	NO	_____
Thyroid Disease	YES	NO	_____
Depression	YES	NO	_____
Dementia	YES	NO	_____
Respiratory Illness	YES	NO	_____
Drug Abuse/Habits	YES	NO	_____

Your Personal Habits:		
Exercise regularly?	YES	NO
Smoke or use tobacco?	YES	NO
How much? _____		
For how many years? _____		
Use tobacco in the past?	YES	NO
Drink Alcohol	YES	NO
How much? _____		
Have you ever blacked out?	YES	NO
Would you like to cut down?	YES	NO
Caffeine consumption?	YES	NO

PAST SURGICAL HISTORY- Please list any operations you have had:

_____
_____
_____
_____
_____
_____

MENTAL HEALTH

Is stress a major problem for you?	YES	NO
Do you feel depressed?	YES	NO
Do you panic when stressed?	YES	NO
Do you have problems with eating or your appetite?	YES	NO
Do you cry frequently?	YES	NO
Have you ever attempted suicide?	YES	NO
Have you ever seriously thought about hurting yourself?	YES	NO
Have you ever been to a counselor?	YES	NO

PATIENT SIGNATURE: _____ **DATE**: _____

the GROVE Primary Care Clinic, LLC.

GENERAL CONSENT FOR TREATMENT

1. _____ consents to examination, care and treatment from the physicians and other healthcare professionals of the GROVE Primary Care Clinic, LLC. including but not limited to tests deemed necessary, medical treatment and surgical procedures.

2. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me by the staff at the GROVE Primary Care Clinic, LLC. as to the results of diagnosis, examinations or treatments by the staff or facilities and healthcare providers they refer to me to.

3. I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, and their respective agents, for purposes including, but not limited to payment, utilization review and quality assurance review, and to support applications for patient programs.

4. I hereby authorize, the GROVE Primary Care Clinic, LLC. to contact me via phone, mail, and my given email address with clinic results and with generalized clinic messages they deem reasonable to send me for management of my health and in answer to questions generated by me.

5. I hereby agree that a photocopied, digital or faxed copy or transmission of this authorization is as valid as the original.

6. I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the GROVE Primary Care Clinic, LLC. This assignment is for services rendered to me by the medical providers and the staff at the GROVE Primary Care Clinic, LLC. This assignment will remain in effect until revoked by me in writing or revoked by a medical provider in writing. A photocopy/email of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize the GROVE Primary Care Clinic, LLC. to release all information necessary to secure this payment. I understand that failure to notify the GROVE Primary Care Clinic, LLC. of any changes or insurance coverage may result in the financial obligation to rest fully on me regardless of any contract between the insurance company and the medical providers and the GROVE Primary Care Clinic, LLC.

_____ _____

Signature of Patient/ Authorized Representative Date

_____

Signature of Staff Member

the GROVE Primary Care Clinic, LLC.

RELEASE OF INFORMATION

Please list a family member or friend; someone that is okay to release medical information to in case of an emergency.

I, _____, give the office of the GROVE Primary Care Clinic, LLC**.** permission to release health information to (include the name and their relation to you):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Do not release my information

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that a copy of the medical office the GROVE Primary Care Clinic Notice of Privacy Practices has been made available to me.

_____
PLEASE PRINT PATIENT'S NAME

_____ _____
PATIENT SIGNATURE (if other than the patient, please state your relation to patient) DATE

ADVANCED DIRECTIVES

Do you have a living will or durable power of attorney? YES _____ NO _____

If you have a durable power of attorney, please identify: _____

Would you like us to give you a packet of information regarding advanced directives?

YES _____ NO _____

_____ _____
PATIENT (OR GUARDIAN) SIGNATURE DATE

_____ _____
WITNESS (office staff can witness) DATE

the GROVE Primary Care Clinic, LLC.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

AGENCY REQUESTING PROTECTED HEALTH INFORMATION

the GROVE Primary Care Clinic, LLC.

☐ 541 West Park Place Henderson, TN 38340 P: 731.983.0499 F: 731.983.0573	☐ 702 S. Main Street Middleton, TN 38052 P: 731.376.1311 F: 731.376.1314	☐ 9458 Highway 100 Scotts Hill, TN 38374 P: 731.549.3010 F: 731.549.3013

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PURPOSE OF DISCLOSURE

☐ Medical Care	☐ Insurance	☐ At the Request of the Patient	
☐ Other, Please Explain: _____			
Description of Information to be Used or Disclosed:			
Dates of Treatment:		Place of Treatment:	
Choose From the Following:			
☐ All Dictated Reports	☐ Lab (may include AIDS/HIV)	☐ Discharge Summary	☐ Pathology Reports
☐ Radiology Report	☐ Consultation	☐ Anesthesia Record	☐ Billing Record
☐ ER Records	☐ Other (specify):		

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows **The Grove Primary Care Clinic** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information; I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The Office of **The Grove Primary Care Clinic** is hereby released from any liability and the undersigned will hold **The Grove Primary Care Clinic** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire one (1) year from this date unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to **The Grove Primary Care Clinic** from the facility named above.

Signature of Patient	Signature of Patient's Authorized Representative
Date	Description of Representative's Authority to Act for Patient