Smith County Family Medical

Date : _____ Email address : _____

Full Name of Patient: _____ DOB : _____

Home address : _____ City : _____

State: _____Zip : _____ S.S # _____ Gender: M or F

Phone Number : _____ 2nd phone # _____

Marital Status : ___married ___single ___divorced ___ widowed _____other

Name of spouse: _____

Insurance Policy holder Name: _____

DOB : _____ SS # : _____

Must have this information to file insurance claims if you are not the insurance policy holder

Lab protocol:
As a courtesy to our patients, we collect labs and send to our lab. If your insurance requires you to use a certain in-network lab, it is the patient's responsibility to notify our clinic so we can send samples to the chosen lab. Labs are done on a regular basis depending on your diagnosis and prescribed medications.

Refill protocol:
Please note that if you are out of refills then it is time for a follow up visit at our clinic. You will need to contact our office within a couple weeks after picking up your last refill to set up an appointment to come in for you follow up and refills.

Please sign below that you have read and understand the lab and refill protocol.

_____ Date: _____

If you have had a change in insurance since your last appointment it is your responsibility to provide us with a new card. Once your office visit has been filed and it is denied you will be help responsible for that balance . IF YOU NO SHOW FOR AN APPOINTMENT YOU WILL BE CHARGED $ 40.00 AND THIS MUST BE PAID BEFORE YOU ARE SEEN AGAIN.

We would love to know how you heard about our office:

_____ **Friend** _____ **Family Member** _____ **Co-Worker** _____ **Facebook** _____ **Google**

List any hospital stays, surgery's or childhood illness (reason and dates)

_____ _____
_____ _____
_____ _____

List any allergies to medication, food or any other allergies along with **what type of reaction : please list what reaction you have to each medication(example: rash, upset stomach, trouble breathing)**

_____ _____
_____ _____

List medication that you currently take, including over the counter :
Please include name of medication, strength, directions and reason for taken (diagnosis)

Name	Strength	directions	diagnosis

if more space is needed you can list on back of this sheet

List name and numbers to any specialist you see and for what reason :

_____ _____
_____ _____

Name of Pharmacy: _____

List everyone in your household including pets :

_____ _____ _____
_____ _____ _____

Do you have a living will ? ____ yes ____ no Do you have a POA ____ yes _____no

Someone whom does not live in home (for emergency) : _____ phone # _____

How did you hear about our practice ? _____

Please record the last year you had the following. If you are unsure leave blank:

Hep B (shot) _____
Flu vaccine _____
Pneumonia shot _____
Tetanus shot _____
Shingles shot (zoster or Shingrix) _____
Nutritional therapy _____
AAA screening _____
Bone density scan _____
Colonoscopy _____
Diabetes Training _____
Echocardiogram _____
Eye Glaucoma exam _____
Glucose _____

Hearing exam _____
Hemocult _____
Lipid Panel _____
Mammogram _____

Pap smear _____
Pelvic exam _____
Prostate Exam _____
PSA test _____
Rectal exam _____
Smoking cessation _____
Covid Vaccine _____

Hippa Disclosure Form

Patient Name: _____ Date of birth: _____
May we identify ourselves over the phone? ___ yes ___ no
May we leave message about appointments and lab results ? ____ yes ____ no

I, the Patient or guardian hereby authorize Smith County Family Medical to release my medical information (appointments, labs, diagnoses, medications or etc) via phone, fax or email to the following listed below :

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Sign: _____ Date: _____

Hippa Disclosure for test results, appointments and referrals

I, the Patient or guardian hereby authorize Smith County Family Medical to email, text or leave voice mail with any information regarding my laboratory results, referrals or appointments.
Yes _____ No _____

Patient name: _____
Date : _____
Signature: _____

It is very important that we have your cell phone, home phone and email to be able to reach out to you

Name: _____ DOB: _____

Social History:

Tobacco use:
____ smoke ___ smokeless tobacco ____ vape

Current user: _____ Prior use: _____ Quite date: _____
Are you interested in quitting ? _____ yes ____ no

Alcohol use: _____ Never _____ Occasional _____ Daily
Caffeine use: _____ Never _____ Occasional _____ Daily
Illegal Drug: _____ Never _____ Occasional _____ Daily

Occupation: _____

Exercise: Type/Frequency _____

Family History:

	FATHER	MOTHER	BROTHER	SISTER	MGM	MGF	PGM	PGF
Deceased:								
hypertension								
heart disease								
stroke								
kidney disease								
obesity								
genetic disorder								
alcoholism								
liver disease								
depression								
colon cancer								
breast cancer								
other cancer								

Smith County Family Medical HIPPA

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
All Professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. All services provided to you as a patient of Smith County Family Medical, LLC are payable at time of service and are the sole responsibility of you " the patient" and /or guarantor of your children. In the event that I default in the obligation of payment to my provider, I understand that my accounts(s) can be placed with a collection agency or attorney for collections. I further agree to pay reasonable attorney fees, collections fees, and court costs if my account(s) is placed for legal or third-party collection action. I hereby authorize Smith County Family Medical, LLC to furnish insurance companies or their representatives information concerning my illness and treatments and I hereby assign to Smith County Family Medical, LLC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance . I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical exam, studios, laboratory procedures or any clinical service that he/she deem necessary in my case, and I further authorize him/her to disclose to the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital or medical services company, insurance company, workers compensation carriers, welfare funds or the patients employer .

PATIENT INFORMATION CONSENT:
I understand the Smith County Family Medical, LLC may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment for obtaining payment for services, and for the purpose of the practice. I consent to the use of my information for the purpose of treatment, payment, and healthcare operations.

I understand that my consent is not needed if the law requires. The law requires Smith County Family Medical , LLC to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease and potential bodily harm to myself or others)

I understand that I have the right to review Smith County Family Medical, LLC privacy notice, to request restrictions be put on the use of my information and to revoke my consent at a later date.

I understand that if I withold consent for the use of my information for the purpose of treatment, payment or operations, Smith County Family Medical, LLC may refuse to undertake my care.

I, the undersigned, hereby consent to the following treatment: administration and performance of all treatments, of any needed anesthetics, perfomracc of such procedures as may be deemed necessary or advisable in the treatment of the patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies, and surgery, performance of other medically accepted laboratory test that may be considered medically necessary or advisable base on the judgment of the attending physician or their assigned design. I fully understand that is is given in advance of any specific diagnosis or treatment. I intern d this consent to be continuing in nature even after a specific diagnoses has been made and treatment ed. The consent will remain in full force until revoked in writing, I understand the Smith County Family Medical, LLC may include consent at satellite offices under common ownership

HIPPA ACKNOWLEGMENT:
I have read Smith County Family Medical, LLC notice of privacy practices. In my absence or for the benefit of gaining medical advice on my behalf , I authorize the following person to gain patient health information for or with me :

_____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO IT CONTENT. ALSO THAT ALL INFORATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE .

Patient/Guardian Signature _____ Date

_____

Past or Present Medical History

Have you ever been diagnosed with or currently have any of the following health issues?

___ Alcohol/Drug Problem

___ Arthritis

___ Acid Reflux

___ Cancer (Type: _____)

___ Heart Arrhythmia

___ Heart Surgery

___ Dementia

___ Anxiety

___ Emphysema

___ Hepatitis (Type: _____)

___Kidney Disease

___Liver Disease

___Osteoporosis

___TB

___Prostate Problems

___ Anemia

___ Asthma

___ Blood Clots

___ AFIB

___ Palpitations

___ Congestive Heart Failure

___ Depression

___ Diabetes

___ High Blood Pressure

___ Seizure Disorder

___ High Cholesterol

___ Sleep Apena

___ Stroke

___ Thyroid Disease

___ Ulcers

Other not listed above:

_____

_____