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 Path Group. 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 arrange to have your labs done at the chosen lab. Labs are done on a regular basis depending on your diagnosis and prescribed medications. Your provider will go over with you what labs you need.

Labs are sent to the laboratory and they bill independently. We have no control on what your insurance will be billed . We also have no control on what your laboratory deductible and /or copay will be. For billing questions regarding labs you will need to contact the laboratory company.

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 .

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 :

_____ _____
_____ _____

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

Next of Kin (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: _____ Age: _____ DOB:_____ Today's Date: _____

Social History check all that apply:

Tobacco Use: ☐ Cigarettes ☐ Chew ☐ Cigars ☐ Snuff ☐ 2nd Hand	☐ Never ☐ Prior Use Quit date: _____ Frequency: _____ cigs/pack day/week # of years: _____ Are you interested in quitting? ☐ Yes ☐ No
☐ Alcohol: ___ Never ___ Occasional ___ Daily ☐ Caffeine: ___ Never ___ Occasional ___ Daily ☐ Illegal Drugs: ___ Never ___ Occasional ___ Daily ____ Prior ☐ Quit Date: _____	
Occupation:	Exercise (Type/ Frequency):

Family History – Please use a check mark to indicate a positive history.

	Self	Father	Mother	Brother	Sister	Aunt	Uncle	Daughter	Son
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression									
Colon Cancer									
Breast Cancer									
Other Cancer									
Other									

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

___ Alcohol/Drug Problem

___ Anemia

___ Arthritis

___ Asthma

___ Acid Reflux

___ Blood Clots

___ Cancer (Type: _____)

___ AFIB

___ Heart Arrhythmia

___ Palpitations

___ Heart Surgery

___ Congestive Heart Failure

___ Dementia

___ Depression

___ Anxiety

___ Diabetes

___ Emphysema

___ High Blood Pressure

___ Hepatitis (Type: _____)

___ Seizure Disorder

___Kidney Disease

___ High Cholesterol

___Liver Disease

___ Sleep Apena

___Osteoporosis

___ Stroke

___TB

___ Thyroid Disease

___Prostate Problems

___ Ulcers

Other not listed above:

_____

_____

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. 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 ot the following treatment: administration and performance of all treatments, of any needed anesthetics, perfomrace 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

MEDOCARE PATIENTS: I authorize to release medical information about me to the social security administration or its intermediaries for my medicare claims. I assign the benefits paable for services to **Smith County Family Medical, LLC**

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 _____