CMPM - Patient Information Sheet

Driver's License - Please provide DL or State Photo ID and Military ID with this form

ID Type _____ State of Issue _____ ID # _____

Name: Last _____ First_____ Middle Intl. _____ Sex _____

(Preferred)_____ (Suffix Jr, II etc.) _____ (Maiden)_____

Date of Birth _____ SS#_____ Race _____ Ethnicity _____

Marital Status _____ Primary Language _____ Religion _____

Mailing Address: _____

City _____ State _____ Zip_____

Phone # (Home)_____ (Work) _____ (Cell)_____

Best Phone # to reach you at? _____Email Address _____

Emergency Contact: _____ (Phone #) _____ (Relationship) _____

Preferred Pharmacy Name _____ Phone Number _____

Prescription By Mail Service Name _____ Phone Number _____

Insurance Information: Fill in or provide the Insurance Card(s) With This Form

Primary Insurance:

Name of Insurance Company _____ Policy Number _____

Insurance Company's Billing Address _____City _____ State____ Zip_____

Primary Policy Holder

Name_____ Relationship _____ Date of Birth _____

SS# _____ Primary Policy Holder's Phone # _____

Secondary Insurance:

Name of Insurance Company _____ Policy Number _____

Insurance Company's Billing Address _____City _____ State____ Zip_____

Primary Policy Holder

Name_____ Relationship _____ Date of Birth _____

SS# _____ Primary Policy Holder's Phone # _____

*** Twenty four hours' notice must be given when cancelling or rescheduling an appointment. Failure to do so may result in the appointment being marked as a 'no-show', incurring up to a $75 charge to your account.**
*** Your signature below indicates the information you have provided is correct to the best of your knowledge and that you have received a copy of our privacy statement.**

Signature _____ Date _____

SIGNATURE SECTION

To the best of my knowledge, the information on the registration form is complete and correct. I understand that it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature:_____ Date:_____

CONSENT TO TREATMENT

I voluntarily consent to medical care at **Consolidated Medical Practices of Memphis** for routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistance, medical assistants, or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at **Consolidated Medical Practices of Memphis**

I promise as a patient of **Consolidated Medical Practices of Memphis** to I will follow all office policy that pertain to the patients of the office. I understand that if I am not compliant with following the physicians' plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature:_____ Date: _____

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers, and independent contactors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature:_____ Date: _____

BENEFIT AUTHORIZATION

(a) I authorize **Consolidated Medical Practices of Memphis** to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
(b) I also request that payments of authorized benefits be made to me or on my behalf to **Consolidated Medical Practices of Memphis** for services rendered.
(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.
(d) I authorize the use of my signature on all insurance submissions.
(e) I understand I am responsible for payment of all medical expenses incurred due to services rendered at the time of service.
(f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff of any changes.

Patient Signature:_____ Date: _____

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding insurance and billing concerns.

Name:_____Phone #:_____Relationship:_____

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding my health care, plan of treatment, medications, and lab/test results.

Name:_____Phone #:_____Relationship:_____

ACCOUNT COLLECTIONS AGREEMENT

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. In the event your account is placed with an Attorney, you will be responsible for the reasonable Attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient Signature: _____ Date: _____

Threlkeld, Threlkeld, & Omer, PLLC

Patient Health History

Patient Name: _____ Today's Date: _____ Date of Birth: _____

Allergies (Seasonal, Food and Medication): _____

List ALL MEDICATIONS you take, including over-the-counter (OTC), vitamins, and supplements. (additional space on pg. 2)

Name of Medication	Dosage	Frequency

Personal Medical History: (Please check all that apply)

- ○ Alcoholism
- ○ Arrhythmia
- ○ Arthritis
- ○ Asthma
- ○ Blood Disorders _____
- ○ Cancer _____
- ○ COPD/Emphysema
- ○ Dementia
- ○ Diabetes: 1 or 2
- ○ Disorders of the eye _____
- ○ DVT (Blood Clot)
- ○ Gastrointestinal Diagnosis _____
- ○ Heart Attack (MI)
- ○ Heart Disease
- ○ Hepatitis _____
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ HIV
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Liver Disease
- ○ Migraine Headache
- ○ Neuropathy
- ○ Osteopenia/Osteoporosis
- ○ Parkinson's disease
- ○ Peripheral Vascular Disease
- ○ Psoriasis
- ○ Rheumatoid Arthritis
- ○ Seizure Disorder
- ○ Sleep Apnea
- ○ STD _____
- ○ Stroke
- ○ Thyroid Disorder

Other medical problems not listed: _____

Past Surgeries and Hospitalizations (Please include location and year): _____

Do you smoke? If yes, How many cigarettes per day? _____ How long have you smoked? _____

How many alcoholic beverages do you consume in an average week? _____

Recreational Drug use? Please, share what and how often. _____

Family History: (Please check all that apply and circle M for Mother and/or F for Father)

Mother: Age (or age at death) _____

Father: Age (or age at death) _____

- ○ DVT (Blood Clot) M / F
- ○ Heart Disease M / F
- ○ High Cholesterol M / F
- ○ High Blood Pressure M / F
- ○ Kidney Disease M/ F
- ○ Stroke M / F
- ○ Alcoholism M / F
- ○ Anemia M/F
- ○ Cancer: M/F _____
- ○ COPD/Emphysema M / F
- ○ Dementia M / F
- ○ Diabetes 1 or 2 M / F

Name of Person Completing this form: _____Relationship to Patient _____

Signature of Person Completing this form: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC), vitamins, and supplements.

Name of Medication	Dosage	Frequency

Other Notes: