CREEKMORE CLINIC, PLLC

NEW PATIENT INFORMATION Date: _____

Name _____ Sex _____ Marital Status _____
Date of Birth _____ Age _____ Race _____
Social Security # _____ Drivers License # _____
Mailing Address _____
City, State, Zip _____
Phone # Home _____ Cell _____ Work _____
Patient Email _____
Occupation/Employer _____
Emergency Contact: Name _____ Number _____

PARENT/GUARDIAN INFORMATION of a child younger than age 18
Name _____ Relationship _____
Date of Birth _____ Social Security _____
Mailing Address _____
City, State, Zip _____

PATIENT INSURANCE INFORMATION Will need copies of card(s)
Primary Insurance Name _____ DOB _____
Insurance Company _____
ID# _____ Group# _____
Secondary Insurance Name _____ DOB _____
Insurance Company _____
ID# _____ Group# _____

Medicare# _____ Medicaid# _____

PAYMENT REQUESTED AT TIME OF SERVICE---UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Creekmore Clinic for services rendered by Creekmore Clinic, PLLC, by their medical staff in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Creekmore Clinic, PLLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payments is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as original.

Patient _____ Date: _____
Parent/Guardian _____ Date: _____

PATIENT HISTORY FORM

Creekmore Clinic, PLLC

Sam Creekmore, M.D. Brad Scott, D.O.

Hailey Davis, FNP-C Correal Garrison, FNP-C Heaven Robbins, FNP-C Lyndie Scott, FNP-C

Patient Name: _____ Date: _____

Past Medical History

___Abnormal Weight Gain
___Abnormal Weight Loss
___Alcoholism
___Alzheimer's Disease
___Angina
___Anxiety Disorder
___Arthritis
___Asthma
___Auto Immune Disease
___Bronchitis
___Bruise easily
___Cancer
Type_____
___Congestive Heart Failure
___Crohn's Disease
___Diabetes Mellitus (type I) (type II) (Unknown)
___Diverticulitis of Colon
___Esophageal Reflux
___Free Bleeder
___Heart Palpitations
___Heart Attack
___Hepatitis (A, B or C)
___HIV/AIDS
___Hypertension
___Obesity
___Peptic Ulcer Disease
___Pneumonia
___Seizures
___Sickle Cell Anemia
___Sleep Apnea
___Stroke
___Ulcerative Colitis
___Vascular Disease

Past Surgical History

___Adenoids
___Appendix
___Back Surgery
___Brain Surgery
___Breast Surgery
___Colon surgery
___C-Section
___Gall Bladder
___Heart Surgery
___Hemorrhoids
___Hernia Surgery
___Hysterectomy
___Lung Surgery
___Reflux Surgery
___Thyroid
___Tonsils
___Vascular Surgery

Family History ___ Relationship to Pt.

___Breast Cancer _____
___Ovarian Cancer _____
___Colon Cancer _____
___Heart Attack _____
___Sickle Cell Anemia _____

Medication Allergies

Medication_____
_____

Habits

___Smoking Amount _____
___Alcohol Amount _____

Reproductive History

___Number of pregnancies

Signature: _____ Date_____

I, the above signed patient have answered these questions to the best of my knowledge.

NOTICE OF HEALTH INORMATION PRACTICES SIGN-OFF FORM

By my signature below, I acknowledge that:

1. I have received a copy of the ***Notice of Health Information Practices.***
2. I have read, or have had read to me, the entire ***Notice of Health Information Practices.***
    a. States the normal uses and disclosures of patient information.
    b. Outlines Creekmore Clinic's responsibilities under the HIPPA privacy Rule.
    c. Details my rights as a patient or legal representative of a patient.

The original of this ***Notice of Health Information Practices Sign-Off Form*** will be retained with my medical record and a copy will be made for my records.

Signature of Patient or Legal representative: _____

Date and Time: _____

Print Patient's Name: _____

Print Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

Consent Form

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

I give Creekmore Clinic, PLLC permission to render treatment and procedures by physicians, members of the house staff and employees of Creekmore Clinic. The undersigned has read and understood this Consent Form and certifies that no guarantee or assurance has been made as to the results that may be obtained.

I understand that as part of my health care, Creekmore Clinic originates and maintains health records describing my health history, symptoms, examination and rest results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health professionals who contribute to my care
3. a source of information for applying my diagnosis and surgical information to my bill
4. a means by which a third-party payer can verify that services billed were actually provided
5. and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Creekmore Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Creekmore Clinic has already take action in reliance thereon.

I authorize Creekmore Clinic to release any information acquired in the course of examination and treatment in connection with Creekmore Clinic visit for the purpose of insurance and Medicare benefit payments to Creekmore Clinic and the Physician. If covered by valid medical insurance, I authorize payment directly to Creekmore Clinic the benefits herein specified and otherwise payable to me, and authorize release of information for insurance purposes. I agree to pay for the services upon release of about named patient.

Signature of Patient or Legal Representative _____ Date_____

Print Patient's Name _____

Print Name of Legal Representative (if applicable) _____

Relationship to Patient _____

MEDICATION LIST

Patient Name: _____ Date: _____

Medication Names	Dosage	Prescribing Physician
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Review of Systems

Constitutional
- Weight Change _____
- Night Sweats _____
- Fevers _____

Cardiovascular
- Chest Pain _____
- Palpitations _____
- Swelling hands/feet _____

Endocrine
- Excessive Thirst _____
- Thyroid Disease _____
- Hormone Imbalance _____

Neurological
- Frequent Headaches _____
- Convulsions/Seizures _____
- Numbness/Tingling _____

Gastrointestinal
- Nausea/Vomiting _____
- Difficulty Swallowing _____
- Heartburn _____
- Abdominal Pain _____
- Rectal Bleeding _____
- Black Tarry Stools _____
- Hemorrhoids _____
- Constipation _____
- Diarrhea _____

Respiratory
- Shortness of Breath _____
- Wheezing/Asthma _____
- Chronic Cough _____

Hematologic/Lymphatic
- Bruise Easily _____
- Slow to Heal _____
- Enlarged Glands _____

Integumentary (skin/breast)
- Breast Lump/Mass _____
- Breast Pain/Discharge _____
- Changes in Lesions/Moles _____

Genitourinary
- Blood in Urine _____
- Kidney Stones _____
- Painful Urination _____
- Excessive Urination _____
- Menstrual Problems _____
- Testicle Pain _____

Ears/Nose/Mouth/Throat/Eyes
- Hearing Loss/Ringing _____
- Hoarseness _____
- Glasses/Contacts _____
- Blurred/Double Vision _____
- Eye Disease/Injury _____
- Glaucoma _____