Weaver Health Services, LLC.

Ringgold Ready Clinic / Flintstone Ready Clinic

Walk In & Family Medicine

Patient Information

Please print

Legal First Name _____ Legal Last Name _____ Preferred First Name _____

Male/Female _____ Date of Birth _____ Social Security # _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Email _____ Would you like email appointment reminders? Yes No

Preferred Method of Communication E-mail Home Cell Work

Address _____

Preferred Pharmacy _____

Can we retrieve your prescription history from your pharmacy? Yes No

Responsible Party's Information/Guarantor: _____
Inital here if same as above

Name _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____

Address _____ Phone # _____

Ethnicity (Circle) Hispanic Latino Non-Hispanic

Race (Circle) American Indian Asian Black/African American
Native Hawaiian or Other Pacific Islander White Other

Name of Emergency Contact/Next of Kin _____

Relationship to Patient _____ Phone # _____

Address _____

_____

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Insurance Information

Please present your insurance card and ID with this form if you have not already done so.

Primary Insurance Plan Name _____

Secondary Insurance Plan Name (If applicable) _____

If policy holder name is different than patient, please fill out below.

Subscriber Name _____ Relationship to patient _____

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, finding and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writting.

In the event we are unable to reach you by phone, may we leave a detailed message on your voice mail? Yes No

Weaver Health Services

DBA/ Ringgold Ready Clinic - Flintstone Ready Clinic

CONSENT FOR TREATMENT - ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name: _____ DOB: _____/_____/_____

1. CONSENT TO TREAT: I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Weaver Health Services and its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been made to me as a result of the treatment of care.

2. ASSIGNMENT AND RELEASE: I have medical insurance and assign directly to Weaver Health Services physicians all medical benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. In the event of default of payment, I agree to pay all costs of collections including attorney fees. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. FINANCIAL AGREEMENT: I will make every effort to actively assist Weaver Health Services with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Weaver Health Services submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Weaver Health Services to process insurance claims, I will be responsible to pay Weaver Health Services full and standard fees.

4. STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN): I request that payment of authorized Medicare benefits be made on my behalf to Weaver Health Services for services furnished to me by a Weaver Health Systems clinic, including physician services. I authorized any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and Its agents any information needed to determine these benefits or benefits for related services.

CONTROLLED MEDICATION POLICY ACKNOWLEDGEMENT

I understand that Ringgold Ready Clinic is primarily staffed with nurse practitioners. In the state of Georgia, a nurse practitioner cannot order/prescribe Schedule II narcotics, therefore, these will not be written unless the MD sees me and prescribes them to me. These medications include, but are not limited to Adderall, Hydrocodone, Oxycodone, Ms Contin, and Percocet. I further understand that no other controlled substance will be called in after normal operating hours of the clinic. I also agree to comply with all state and federal regulations regarding random drug testing as well as being seen intermittently by the MD for any scheduled medications that are written by the NP. If requirements are not met, I understand that refills will not be given.

_____	_____	____/____/____
Printed Name of Patient/Authorized Representative	Signature of Patient/Authorized Representative	Date

RECEIPT OF HIPAA PRIVACY NOTICE: I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices." I understand the Notice of Privacy may change over time and that the obligations of Weaver Health Services and my rights under it may change. **Initial:** _____.

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MEDICAL HISTORY for ADULTS

Patient's Name: _____

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

Reason for todays visit _____

YOUR MEDICAL HISTORY - Please indicate if YOU have a history of the following:
Please CIRCLE all that apply

I HAVE NO SIGNIFICANT MEDICAL HISTORY

Alcohol Abuse
Allergies/Sinus
Alzheimers
Anemia
Anxiety
Arthritis
Asthma
Birth Defects
Bleeding Disease
Blood Clots
Breast Cancer
Bipolar Disorder
Cataracts
Colon Cancer
Congestive Heart Failure
COPD/Emphysema
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes Type 1
Diabetes Type 2 (adult onset)
Gout
Heart Attack
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Hypothyroid (Low Thyroid)
Irritable Bowel Syndrome (IBS)
Kidney Stones
Liver Cancer
Lung Cancer
Lupus
Migraines
Multiple Sclerosis
Osteoporosis
Parkinson's Disease
Prostate Cancer
Prostate Problems
Reflux / GERD
Rheumatic Fever
Rheumatoid Arthritis
Seizures / Convulsions
Sexually Transmitted Disease
Sleep Apnea
Stomach Ulcer
Stroke / CVA of the Brain
Suicide Attempt
Tuberculosis (TB)

Other Disease, Cancer or Significant Medical Illness (please specify):

_____

SOCIAL HISTORY Are you employed? _____ Occupation: _____ Marital Status M S D W

TOBACCO/ALCOHOL USE

What is your smoking status?
- ❑ Never Smoke
- ❑ Former Smoker
- ❑ Currently every day smoker

If current smoker how many packs per day?_____

Gender:
- ❑ Male
- ❑ Female
- ❑ Transgender Male
- ❑ Transgender Female
- ❑ Decline to answer

Sexual Orientation:
- ❑ Straight / Heterosexual
- ❑ Lesbian / Gay / Homosexual
- ❑ Bisexual
- ❑ Don't know
- ❑ Decline to answer

Do you drink alcohol?
If so, what type and how often? _____

SURGICAL HISTORY Please CIRCLE all surgeries you have had:

I HAVE HAD NO SURGERIES

Appendectomy
Breast Augmentation
Breast Lumpectomy
Breast Reduction
Carotid Artery
Cataract
Foot
Gallbladder
Heart Bypass
Hysterectomy (due to cancer)
Hysterectomy (not due to cancer)
Inguinal Hernia
Kidney Removal
Knee
Low Back Disc
Lung
Mastectomy
Neck Disc
Ovary Removal
Pacemaker
Prostate
Shoulder
Sinus
Thyroid Removal
Tonsillectomy
Total Hip Replacement
Total Knee Replacement
Tubal Ligation
Vasectomy
Weight Loss

List any other surgeries: _____

ALLERGIES ❑ No known allergies

DRUGS	SEVERITY			ONSET		
	Mild	Mod	Severe	Child	Adult	Unknown

Any other allergies to food or environment? _____

FAMILY MEDICAL HISTORY

- ❑ ADOPTED
- ❑ FAMILY HISTORY UNKNOWN
- ❑ NO SIGNIFICANT FAMILY MEDICAL HISTORY

- ❑ **Mother, Grandmother**, or **Sister** developed Heart Disease before the age of **65**.
- ❑ **Father, Grandfather**, or **Brother** developed Heat Disease before the age of **55**.

Please indicate which family member(s) have had these illnesses:	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother	Sister
Alcohol Abuse								
Anemia								
Arthritis								
Asthma								
Bipolar Disorder								
Bleeding Disease								
Breast Cancer								
Colon Cancer								
COPD / Emphysema								
Depression								
Diabtes Type 1								
Diabetes Type 2 (adult onset)								
High Blood Pressure								
High Cholesterol								
Osteopotosis								
Seizures / Convulsions								
Stroke / CVA of the Brain								

❑ Other Family Medical History (specify illness & family member):

_____

PREVENTATIVE HEALTH

Please indicate when you last had each of the applicable tests:	N/A	1 year or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10+ years ago	Normal	Abnormal	I Don't Know
Mammogram														
Colonoscopy														
Pap Smear														
Bone Density / Dexa Scan														
Prostate Cancer Screening														
Stool Hemoccult (blood in stool)														
Eye Exam														

List all medications you are currently taking: _____

LIVING WILL/POWER OF ATTORNEY

Do you have a Living Will or Power of Attorney for your healthcare? If yes, list details _____