State of Franklin HEALTHCARE ASSOCIATES™

Your Health, Our Focus

Personal History
FirstChoice Family Practice

Name: _____ Sex: _____ Age: _____ Date of birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____ Email: _____

List names of additional physicians you see: _____

_____

Date of last Exam: _____

Social History

Occupation: _____ Employer: _____

Marital Status: _____ Living Situation: _____

Education Level: _____ Sex Partner: Male _____ Female _____

Hobbies/Interests: _____

_____

Habits: (Check those that apply to you)

( ) Smoke Cigarettes or Cigars: how many packs per day? _____ How many years? _____

( ) Smokeless Tobacco (chewing, snuff) How many years? _____

( ) Alcohol: How many drinks per day? _____ Per week? _____

( ) Using or taking illegal drugs?

( ) Wear Seatbelts?

( ) Exercise regularly? If yes: How many times per week? _____

Advanced Directives:

Do you have a living will or medical durable power of attorney? Yes ____ No ____ (if yes please bring a copy with you)

Allergies and Reactions: (please describe reactions)

Medication Allergies_____

Food or Environmental Allergies: _____

Immunizations: (Please bring a copy of your immunization records)

Last Tetanus Shot? _____ (Year) Last Flu Shot? _____ (Year) Last Pneumococcal (pneumonia) shot? _____ (Year)

TB Skin Test? _____ (Year) Positive? _____ Negative? _____

Other Immunizations? (Please list injection and year) _____

_____

Woman's Health

Number of pregnancies _____ Number of children born _____ Method of birth control _____

Date of last Pap smear, pelvic exam? _____ Any abnormal pap smears? _____ if yes please list date _____

Have you had a hysterectomy? _____ Vaginal hysterectomy? (Date) _____ Abdominal hysterectomy? (Date) _____

Was it a total hysterectomy? _____ partial hysterectomy? (also called Supracerival) _____ radical hysterectomy _____

Last menstrual period? (Date) _____ Age of menopause? _____ Hormone therapy? _____

Date of last mammogram? _____

Health Maintenance

Have you had a colonoscopy? Yes _____ No _____ (if yes please list date and physician) _____

Have you had a bone density test? Yes _____ No _____ (if yes please list date/year) _____

When was your last eye exam? (Date) _____ Physician/Clinic _____

Past Surgical History (please list all past surgeries)

Surgery	Date	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (please list ALL medications you are taking including over the counter medications)

Medication Name (Example: Aspirin)	**Dosage/Strength** (Example: 81mg)	**Directions** (Example: once a day in the evening)

Family History (Please select appropriate boxes)

Family Member	Heart Disease	Stroke	Cancer	Diabetes	High Blood Pressure	Deceased	Age
Father	☐	☐	☐	☐	☐	Y N	
Mother	☐	☐	☐	☐	☐	Y N	
Maternal Grandfather	☐	☐	☐	☐	☐	Y N	
Maternal Grandmother	☐	☐	☐	☐	☐	Y N	
Paternal Grandfather	☐	☐	☐	☐	☐	Y N	
Paternal Grandmother	☐	☐	☐	☐	☐	Y N	
Brother #1	☐	☐	☐	☐	☐	Y N	
Brother #2	☐	☐	☐	☐	☐	Y N	
Sister #1	☐	☐	☐	☐	☐	Y N	
Sister #2	☐	☐	☐	☐	☐	Y N	

Past Medical History (please check all that apply)

_____ Acne
_____ Allergies (seasonal)
_____ Alzheimer's disease
_____ Anemia, type _____
_____ Anxiety
_____ Arthritis, type _____
_____ Asthma
_____ Arrhythmia
_____ ADD
_____ B12 Deficiency
_____ Bipolar Disease
_____ Bone Fracture, site _____
_____ Blood Clot, site _____
_____ BPH (enlarged prostate)
_____ Bronchitis (chronic)
_____ Heart Disease (coronary artery)
_____ Cancer, type _____
_____ Carpal Tunnel Syndrome
_____ Cataracts
_____ Chicken Pox, year _____
_____ Colitis
_____ Colon Polyp (benign)
_____ Congestive heart failure (CHF)
_____ Constipation
_____ COPD (emphysema)
_____ Chron's disease
_____ Depression
_____ Diabetes Type l, controlled? Y N
_____ Diabetes Type ll, controlled? Y N
_____ Diabetes, Gestational (diabetes during pregnancy)
_____ Ear Infections (chronic)
_____ Eczema
_____ Epilepsy (seizure disorder)
_____ Erectile dysfunction
_____ Fatigue
_____ Fibromyalgia
_____ Gallbladder disease
_____ GERD (heartburn)
_____ Glucose intolerance
_____ Gout
_____ Headaches (chronic), type _____
_____ Hearing loss
_____ Heart attack, year _____
_____ Heart Disease
_____ Heart Murmur
_____ Heart Palpitations
_____ Heart Valvular Disease
_____ Hemorrhoids
_____ Hepatitis, type _____
_____ High blood pressure
_____ High cholesterol
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Irritable bowel syndrome (IBS)
_____ Kidney Infection
_____ Kidney Stones
_____ Low back pain (chronic)
_____ Liver disease, type _____
_____ Lupus
_____ Menstrual problems, type _____
_____ Mental Retardation
_____ MSRA (skin infection)
_____ Neck pain (chronic)
_____ Obesity
_____ Osteopenia
_____ Ovarian Cysts
_____ Panic attacks
_____ Pneumonia
_____ Polycystic Ovaries
_____ Prostate infection
_____ Restless leg syndrome
_____ Rosacea
_____ Scoliosis
_____ Sexually transmitted disease type _____
_____ Shingles
_____ Sinusitis (chronic)
_____ Sleep apnea
_____ Sleep problems
_____ Stroke
_____ Suicide attempt
_____ Thyroid Nodule
_____ TMJ
_____ Ulcers
_____ UTI (urinary tract infections (chronic)
_____ Urinary incontinence
_____ Vertigo

Other conditions not listed: _____

_____

_____

_____

_____

_____

_____

_____

Voluntary Questionnaire
(You are not require to answer question)

Our electronic medical records system maintains certain demographic information used for a variety of purposes, including reference ranges for patient care and government reporting of statistical information. We ask all new patients to voluntary self-identify the information below and are asking our current patients to confirm it so we may verify our records. Completion of this form is completely voluntary and is not required. The use of information you provided will be consistent with patient care and privacy practices.

Ethnicity Categories	Select One (√)
Hispanic or Latino – person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race	
Non-Hispanic or Latino – person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race	
Race Categories	**Select One (√)**
Black, African American – person having origins in any of the black racial groups of Africa, including those who consider themselves to be Haitian	
Asian – person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan the Philippine Islands, Thailand and Vietnam	
White – person having origins in any of the original peoples of Europe, North Africa, or the Middle East	
American Indian, Alaska Native (not Hispanic or Latino) – person having origins in any of the original peoples of North and South America (including Central America and who maintain tribal affiliation or community attachment	
Native Hawaiian, other Pacific Islander (not Hispanic or Latino) – person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands	
Two or more races, please specify: person having origins in more than one of the above races	
Decline – Do not wish to participate	

_____ _____

Patient Signature or Guardian/Representative **Date**

State of Franklin HEALTHCARE ASSOCIATES™

Your Health, Our Focus

State of Franklin Healthcare Associates, PLLC
Registration, Billing and Collection
Payment Policy

We are participating with Medicare, Tennessee Medicaid, and most Managed Care plans in the area. We will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service. If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage plan, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we will provide you with a completed third party payer claim form to use in filing your insurance.

Patients with a High Deductible Health Plan that have not met their annual deductible amount on the date of service will be asked to pay SoFHA's estimate of the allowed charges at the time of service. You will be billed for any additional deductible amounts after the insurance processes the claim.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you will be liable for.

2. Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient/guarantor.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Any service not covered is the responsibility of the patient/guarantor.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service and we will be happy to assist you in making payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient or Guardian Signature Date