Patient Registration

SOFHA Surgical Group

☐ Andrew Garrett, MD
☐ Michael J. Hodge, MD, FACS
☐ Rebecca Odom, MD

Patient Information

First Name _____ M.I. _____ Last Name _____

Birthdate _____ ☐Male ☐Female Age _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Telephone Number (____) _____ Cell Telephone Number (____) _____ Work Telephone Number (____) _____

Email Address: _____ Patient Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employer's Name _____ Employer's Address _____ City/State _____ Employer's Telephone # _____

Primary Care Physician _____ Referring Physician _____

Referral Source - How did you hear about us? ☐ Physician _____ ☐ Yellow Pages
☐ Billboard ☐ TV Commercial ☐ Internet ☐ Facebook ☐ Newspaper ☐ Signs
☐ Family/Friends ☐ Other (Please Specify): _____

Name of Spouse or Parent _____ Telephone # _____ Employer of Spouse or Parent _____

NAME OF FINANCIAL RESPONSIBLE PARTY AND ADDRESS _____ SSN# _____

In Case of Emergency Notify _____ Relationship _____ Emergency Contact Telephone Number (____) _____

Insurance Information

Primary Insurance _____ Identification Number _____ Group Number _____

INSURANCE SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female SUBSCRIBER'S SOCIAL SECURITY #: _____

SUBSCRIBER'S EMPLOYER _____

Secondary Insurance _____ Identification Number _____ Group Number _____

INSURANCE SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S DATE OF BIRTH: _____ ☐Male ☐Female SUBSCRIBER'S SOCIAL SECURITY #: _____

Authorization

I hereby authorize State of Franklin Healthcare to release to the above companies (or their representatives) any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize and request the above named companies to pay directly to State of Franklin Healthcare any benefits due for their medical or surgical services rendered to me. I permit a copy of these authorizations to be used in place of the original. I understand that I am responsible for payment of any and all charges incurred by me.

Date _____ Signature of Patient or Responsible Party _____

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Patient Acct #_____ Date: _____
For Office Use Only

How many days per week do you exercise? None ___ 3-4 times ___ Daily ___ Every other day ___

Family History

List all major illnesses, or cause of death experienced by your family members (blood relatives)

	DOB	Living	Deceased at age	Major illnesses or cause of death
Mother				
Father				
Sister (s)				
Brother (s)				
Daughter (s)				
Son (s)				

Medical History

Please check if you have had any of the following:

__Diabetes	__Asthma	__Ear Disease	__Bladder Infections
__Thyroid Disease	__Bronchitis	__Sinus Problems	__Prostate Problems
__High Blood Pressure	__Seasonal Allergies	__Ulcers	__Urinary Problems
__Heart Attack	__Colitis, Bowel Disease	__Skin Problems	__Venereal Disease
__Angina (chest pain)	__Liver Disease, Hepatitis	__Chronic Headaches	__Alcoholism
__Heart Rhythm Problem	__Gallbladder Disease	__Seizures	__Depression
__Heart Murmur	__Anemia	__Stroke	__Drug Abuse
__Rheumatic Fever	__Easy Bleeding	__Paralysis	__Nervous Breakdown
__High Cholesterol	__Blood Clots	__Arthritis	__Suicide Attempt
__Lung Disease	__Cancer or Tumor	__Lupus	__Psychiatric Disorder
__Emphysema	__Eye Disease	__Bone Fractures	__Other
__Pneumonia	__Glaucoma	__Muscular Problems	_____
__Tuberculosis (TB)	__Cataracts	__Kidney Stones	_____

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Patient Acct #_____ Date: _____
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Physical Exam Questionnaire

Name:_____ Date:_____

Please check all that apply:

General:
__Feeling Well
__Weight Gain
__Weight Loss
__Fatigue
__Fever

Skin:
__Bruising
__Change in Wart/Mole
__Excessive Sweating
__Hair Loss
__New Lesions
__Rash

Hearing: Eyes, Ears, Nose & Throat:
__Double Vision
__Visual Loss
__Hearing Loss
__Ear Pain
__Ringing in the Ears
__Nose Bleed
__Seasonal Allergies
__Runny Nose
__Sinus Pain

Neck:
__Neck Pain
__Swollen Glands

Respiratory:
__Cough
__Chronic Cough
__Difficulty Breathing
__Wheezing
__Shortness of Breath

Breast (Females Only):
__Breast Mass
__Breast Pain
__Breast Tenderness
__Nipple Discharge

Cardiovascular:
__Chest Pain
__Fainting
__Blacking Out
__Palpitations
__Irregular Heart Beat
__Abnormal Blood Pressure
__Difficulty Breathing Laying Down
__Swelling of Extremities/Edema

Gastrointestinal:
__Abdominal Mass
__Abdominal Pain
__Black, Tarry Stool
__Bloody Stool
__Change in Bowel Habits
__Constipation
__Diarrhea
__Heartburn
__Nausea
__Vomiting

Female Genitourinary:
__Blood in Urine
__Change in Bladder Habits
__Incontinence
__Menstrual Irregularities
__Painful Intercourse
__Painful Urination
__Pelvic Pain
__Urgency
__Urinating at Night
__Vaginal Discharge

Male Genitourinary:
__Blood in Urine
__Change in Bladder Habits
__Impotence
__Testicular Mass
__Urinating at Night
__Need for Erection Meds.

Musculoskeletal:
__Leg Cramps
__Back Pain
__Joint Pain
__Joint Stiffness
__Muscle Pain
__Muscle Weakness

Neurological:
__Decreased Memory
__Difficulty Swallowing
__Headaches
__Numbness
__Tingling
__Seizures
__Tremor
__Dizziness

Psychiatric:
__Anxiety
__Depression
__Insomnia
__Panic Attacks
__Suicidal Thoughts

Endocrine:
__Appetite Changes
__Cold Intolerance
__Excessive Thirst
__Excessive Urination
__Thyroid Problems
__Heat Intolerance

Hematology:
__Abnormal Bleeding
__Anemia
__Blood Clots
__Easy Bruising
__Enlarged Lymph Nodes

SOFHA
State of Franklin Healthcare Associates

No-Show Policy

State of Franklin Healthcare strives to provide excellent, quality care to each and every patient in a timely manner. In an effort to provide care when you need it, we have updated our policies on missed or canceled appointments and patient discharges.

We try to be good stewards of your time and ours. So, when at all possible, please notify us as soon as possible and at least 24 hours in advance when you are unable to keep your appointment. We will assist you in selecting another time better for you and will still be able to allow someone else to be seen.

In addition, we need time to greet you and complete registration for your appointment. Therefore, we ask that you always arrive at least 15 minutes prior to your appointment. Should you be running later than 15 minutes past your appointment time, we may consider this a "no show" but will make an effort to see you.

We realize things happen and you may miss an appointment. We do track missed appointments and will notify you if this happens. Your provider determines how often you need to be seen; so, to receive proper care, you need to keep or reschedule appointments within the time frame discussed at your visit.

We never want to say goodbye to a patient but sometimes circumstances cause us to determine our relationship isn't working the way it should. If you miss or "no show" an appointment three times, you are not receiving the frequency of care you need nor are we able to use that time for another patient in need. At that point, you may be asked to establish with another provider for your care.

We feel a good relationship consists of mutual respect. However, sometimes challenges arise that may cause us to discontinue the relationship. In addition to a trend of missed appointments, other issues that qualify for dismissal include failure to comply with a prescribed treatment plan, inappropriate/ abusive behavior to providers, staff or other patients or failure to pay outstanding balances.

Please let us know if you have any questions related to our policies. We are always available to answer your questions and thank you for the privilege to participate in your care.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient or Guardian Signature Date