Clear Form

Print Form

REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix

Sex: Male☐ Female☐ Patient's Social Security Number_____

Birth date _____ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐

Home Street Address_____

City_____State_____Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Cell Phone Company_____ email address _____

Name of Primary Care Physician_____ Phone #_____

Referral Source_____ Patient's Driver's License Number_____

PHARMACY Pharmacy Name, Address, and Phone Number _____

_____

EMPLOYER OF PATIENT (or Guardian if patient is minor)

Company Name_____

Address_____

City _____State _____Zip_____

Occupation _____ Phone Number(_____)_____

Circle appropriate answer:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Other ☐ Declined

Ethnicity ☐ Hispanic ☐ Non-hispanic ☐ Declined

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____

Date of birth of Guardian_____ SSN of Guardian _____

Driver's License # of Guardian_____

SPOUSE OF PATIENT (or Guardian if patient is minor)

Name_____

Birthdate _____Social Security Number_____

Employer Name_____

Address_____

City_____State_____Zip_____Phone_____

REASON FOR VISIT

Condition related to: Illness_____ Well visit_____Accident_____

Other_____ Date of Accident, if applicable_____

INSURANCE INFORMATION

Insurance Company_____

Insured Name _____Relationship to Patient_____

Group or Policy Number_____ ID #_____

Westbrook Medical Center
7328 Middlebrook Pike
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ **DOB**_____

Review of Systems: (Check all that apply)

Head & Neck
- ☐ Eye Disease
- ☐ Double vision
- ☐ Blurred vision
- ☐ Prior-Ear Surgery
- ☐ Ear Ache
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Nasal Obstruction
- ☐ Nosebleeds
- ☐ Nasal Discharge
- ☐ Altered sense of smell
- ☐ Sinusitis
- ☐ Nasal Polyps
- ☐ Snoring
- ☐ Excessive sleepiness
- ☐ Facial pain
- ☐ Pain with chewing
- ☐ Recent dental work
- ☐ Mouth sores
- ☐ Lumps in the neck
- ☐ Allergies

Respiratory System
- ☐ Hoarseness
- ☐ Chronic cough
- ☐ Throat clearing
- ☐ Heart Burn
- ☐ Regurgitation
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Chest Pain
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Lung cancer

Neurologic
- ☐ Headaches
- ☐ Head injury
- ☐ Numbness or tingling
- ☐ Transient black-outs
- ☐ Transient vision loss
- ☐ Seizures
- ☐ Strokes

General
- ☐ Night Sweats
- ☐ Fevers
- ☐ Skin diseases
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Easy Bruisability
- ☐ HIV infection or AIDS
- ☐ Psychiatric Diseases

Gastrointestinal
- ☐ Difficult swallowing
- ☐ Pain on swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Bloody stools
- ☐ Diverticulosis
- ☐ Gall bladder disease
- ☐ Heartburn or ulcers

Cardiovascular
- ☐ Hypertension
- ☐ Heart disease
- ☐ Angina
- ☐ Swelling of the ankles
- ☐ Heart surgery
- ☐ Angioplasty
- ☐ Pacemaker
- ☐ Anemia

Endocrine
- ☐ Diabetes
- ☐ Heat/cold intolerance
- ☐ Thyroid imbalance
- ☐ Menstrual disorders

Urologic
- ☐ Difficulty on urination
- ☐ Frequent urination
- ☐ Blood in the urine
- ☐ Prostate problems

Other
_____

Past and present medical problems:

_____
_____
_____
_____
_____
_____
_____

Previous surgeries and dates (month/year)

_____
_____
_____
_____
_____
_____
_____

List all current medications and dosages (including OTC):

_____
_____
_____
_____
_____
_____
_____

Do you smoke?
☐ Yes ☐ No
If yes, how much ?_____

Do you drink alcohol?
☐ Yes ☐ No
If yes, how much ?_____

Please list all allergies: (medications, inhalants, foods, contact allergies) _____
_____

Patient Signature_____ **Date**_____

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____ _____

Signature of Patient or Representative | Print Name of Patient or Representative

_____ _____

Date of Signing | Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative | Date

I decline to authorize the above testing:

_____ _____

Signature of Patient or Representative | Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Unless otherwise specified, please release ALL records related to my care.

_____	_____	_____
Printed name of Patient	Patient Date of Birth	Patient Social Security Number

_____	_____
Patient Signature	Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*