Lakeside Health Clinic, P.C.

Patient Information Sheet (ADULT) **Welcome to our Practice**

PATIENT INFORMATION (PLEASE PRINT)

First Name _____ **MI** _____ **Last Name** _____

Preferred Name _____

Social Security # _____ - _____ - _____ **Sex** M F **Date of Birth** _____ / _____ / _____

Gender Identity (please circle one): Male Female Transgender (FTM/MTF) Non-Binary Choose not to disclose

Sexual Orientation (please circle one): Heterosexual Homosexual Bisexual Choose not to disclose

Race (please circle one): Asian Black/African American Native American/Alaskan Caucasian Hispanic Native Hawaiin/Pacific Islander Unknown/Declined

Marital Status (please circle one): Single Married Divorced Widowed

Home Phone (_____) _____ - _____ **Would you like to receive texts from us**

Mobile Phone (_____) _____ - _____→ **reminding you of your appointments? YES NO**

Preferred Contact Method (please circle one): **CALL TEXT EMAIL POSTAL**

☐ **Consent to leave automated text/voice messages on the phone numbers listed above**

Street Address _____

City _____ **State** _____ **Zip** _____

Mailing Address (if different) _____

City _____ **State** _____ **Zip** _____

Email Address _____

Would you like to receive e-mails from Lakeside Health Clinic reminding you of your appointments? YES NO

Would you like access to our Patient Portal? YES NO *REQUIRES EMAIL ADDRESS

Name of Pharmacy _____ **Location of Pharmacy** _____

Mother's Maiden Name _____

EMPLOYER INFORMATION (PLEASE PRINT)

Employment Status (please circle one): Employed Full Time Employed Part Time Self Employed Retired Unemployed Disabled Active Military Student Full Time Student Part Time

Employer _____ **Occupation** _____

Employer Address _____

City _____ **State** _____ **Zip** _____

Employer Phone #: (_____) _____ - _____

RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)

If you are **NOT** the **guarantor** on your insurance information, please fill out the following information for the **guarantor.**

Relation to Patient _____ **If self, please check ☐**

Full Name _____

Date of Birth _____ / _____ / _____ **Social Security #: _____ - _____ - _____**

Phone #: (_____) _____ - _____

Physical Address _____

City _____State _____ Zip _____

Employer _____ Employer Phone #: (_____) _____ - _____

EMERGENCY CONTACT (PLEASE PRINT)

Full Name _____ Relation _____

Physical Address _____

City _____State _____ Zip _____

Home Phone (_____) _____ - _____ **Mobile Phone** (_____) _____ - _____

Do we have consent to contact the above listed person with medical information and appointment information if we are not able to get in contact with you? YES NO

PLEASE LIST ALL MAJOR EVENTS, HOSPITALIZATIONS, & SURGERIES (PLEASE PRINT)
PLEASE PROVIDE DATES & LOCATIONS IF ABLE

PLEASE LIST ALL ONGOING MEDICAL COMPLICATIONS (PLEASE PRINT)
THIS INCLUDES, BUT IS NOT LIMITED TO: DIABETES, HYPERTENSION, HIGH CHOLESTEROL, ANXIETY, DEPRESSION, HEART COMPLICATIONS, PAINS, ETC
PLEASE SPECIFY

SOCIAL HISTORY
(Adult Only 18+)

Do you Smoke? NEVER CURRENT 2ND HAND PRIOR USE
PACKS PER DAY: _____ QUIT DATE: _____

Do you chew tobacco? YES NO

Alcohol Use NEVER OCCASIONAL DAILY HISTORY OF ALCOHOL ABUSE: **(DESCRIBE)**

Caffeine Use NEVER OCCASIONAL DAILY

Drug Abuse NEVER OCCASIONAL DAILY PRIOR USE- QUITE DATE: _____
(Prescription or illicit)
HISTORY OF DRUG ABUSE: **(DESCRIBE)**

FAMILY HISTORY

TO HELP US UNDERSTAND ANY SPECIAL CIRCUMSTANCES FOR YOUR FAMILY, WE NEED TO KNOW IF ANY OF YOUR FAMILY HAS HAD ANY OF THE FOLLOWING. PLEASE CHECT THE APPROPRIATE BOXES. IDENTIFY ALL ILLNESSES OR CONDITIONS IN WHICH YOU KNOW HAVE OCCURED IN YOUR BLOOD RELATIVES.

USE "✓" TO INDICATE POSTIVE HISTORY

	FATHER	MOTHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	SON	DAUGHTER
HIGH BLOOD PRESSURE								
HEART PROBLEMS								
STROKE								
OBESITY								
DIABETES								
ALCOHOLISM								
DRUG ABUSE								
DEPRESSION								
HEPATITIS								
CANCER PLEASE SPECIFY THE TYPE IN THE BOX OF THE AFFECTED PERSON								
SEIZURES								
ASTHMA								
ANEMIA								
HIGH CHOLESTEROL								
BLEEDING DISORDER								
OSETOPOROSIS								
ARTHRITIS								

FEMALE GYN HISTORY
Date of last menstrual period
Problems with Menstruation: Cramping Excessive Bleeding Migraines Other: (describe)
Describe Menstrual Flow: Light Moderate Heavy Clots
Date of Last PAP Smear
Have you ever had an abnormal PAP? YES NO **Date: _____** **Location: _____**
Have you ever had a Mammogram? YES NO **Date: _____** **Location: _____**
History of STD: **Genital Herpes YES NO** **Gonorrhea YES NO** **Trichomoniasis YES NO** **HPV YES NO** **HIV YES NO** **Chlamydia YES NO** **Syphilis YES NO**
Do you use birth control? YES NO **Type: Condoms Pill Depo Shot Implanon Intrauterine Device (IUD)** **Please list pill name in medication list**
Are you sexually active? YES NO
Age at first menses:
Have you ever been pregnant? YES NO
Total # of pregnancies?
Total # of births?

MEDICATION NAME	DOSAGE (MG, McG, mL, etc)	FREQUENCY (How many pills do you take a day & how many times a day)

Medication Allergies	Type of Reaction

Food Allergies	Type of Reaction

Enviromental Allergies	Type of Reaction

Lakeside Health Clinic, P.C.

Patient Authorization Form

Advance Directives

Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable.
3. I will allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless definite financial arrangements have been made prior to the treatment.
5. In the events the charges incurred are not paid in full when due and collection is instituted whether by collection agency, attorney, or both, I agree to be responsible for and to pay in addition to the charges for services and treatment received to all costs associated with such collection activity including, but not limited to, reasonable agency fees, attorney's fees, and court costs.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, and release of information.
8. I consent to have my prescription history retrieved from my pharmacy, my health insurer, and my other healthcare providers.
9. I acknowledge full financial responsibility for services rendered by Lakeside Health Clinic, P.C.
10. I consent to appointment reminders in the form of text, emails, or phone calls.
11. I consent to leave automated text and voice messages on the phone numbers listed in my files.
12. I agree with all the above with the exception of number(s) _____

_____ _____

Patient Signature Date

_____ _____

Lakeside Employee Signature Date

_____

Advance Directive:

Do you have a living will or durable power of attorney? YES NO

If you have a durable power of attorney, please identify:

First Name _____ MI _____ Last Name _____

Relationship _____ Social Security # _____ - _____ - _____

Address _____

Phone #: (_____) _____ - _____ Email Address _____

SIGNATURE REQUIRED EVEN IF YOU MARK "NO"

_____ _____

Patient Signature Date

_____ _____

Lakeside Employee Signature Date

Lakeside Health Clinic's Financial Policy

Lakeside Health Clinic would like to thank you for entrusting us in yours and your family's healthcare needs.

INSURED PATIENTS: Copays, deductibles, and co-insurance are *YOUR* responsibility. Your appointment may be rescheduled if not paid. If you are Out of Network with your insurance, you may responsible for your higher deductibles, copays, and co-insurance. We will not have a total cost of you visit until a claim has been made and your insurance has paid. If you owe anything after the insurance payment, you will receive a bill.

SELF PAY OR UNINSURED PATIENTS: A **$50.00 deposit** is required ***before*** you are seen by a provider in our clinic. The $50.00 is strictly for the office visit. If you receive any shots or have your blood drawn - you will be charged extra. Your appointment may be rescheduled if not paid. If we are Out of Network with your insurance, you may be considered self-pay.

If you do not provide us with the correct insurance information or if your insurance information has changed without our knowledge, you will be charged for your visit.

YOU are responsible for providing us with your new insurance information.

I, _____, have been advised by Lakeside Health Clinic that it is considered "Fraudulent" to not provide ALL of my insurance information at the time of service. I am fully aware that I can be penalized by law through termination of my insurance coverage, fines, and/or imprisonment if the information I provide is false.

I understand that I will be responsible for any charges that were filed, denied, or recouped under false pretense due to my negligence to provide all insurance benefits.

By signing this form, I acknowledge the following:

- **I have provided ALL of my insurance coverage information to Lakeside Health Clinic, P.C.**
- **I am fully aware that I can be penalized by law should I fail to provide all insurance coverage information to Lakeside Health Clinic.**
- **I WILL BE RESPONSIBLE FOR ANY CHARGES THAT WERE FILED, DENIED, OR RECOUPED UNDER FALSE PRETENSE.**
- **I understand Lakeside Health Clinic, P.C. CAN and WILL report any individual who may be guilty or insurance fraud to the Office of Inspector General (OIG).**

If you have any financial questions please contact (731) 924-2000. We will be glad to assist you!

_____ _____

Patient Signature Date

_____ _____

Lakeside Employee Signature Date

Lakeside Health Clinic, P.C

Peter Gardner, MD
Lisa Hubbard, PA-C
813 E Wood St
Paris, TN 38242
(731) 924-2000 P
(731) 653-0053 F

Medical Record Release Form

This form allows us to receive medical records from your most recent **Primary Care Provider** or **Specialists**.

_____ _____

Patient's Name **Date of Birth**

I hereby authorize the below listed facility to release my medical information to Lakeside Health Clinic, P.C.:

Facility: _____ Telephone #: _____

Facility Address: _____ Fax #: _____

_____

Please release information specified below:

_____ Entire Medical Records

_____ Specified records from _____ to _____

_____ Immunizations and Physical Examinations

_____ Imaging Reports

_____ Laboratory Reports

_____ EKG, EEG, EMG

_____ PMH/Family History

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Lakeside Employee Signature Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under federal and/or state law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment from physical and/or mental health illnesses, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS released complex (ARC), or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure information, has already done so in compliance to the consent.

Name: _____ **Date:** _____/_____/_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thought that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___0___ + _____ + _____ + _____

= TOTAL SCORE: _____

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐