



Thank you for taking the time to complete this update form. This data is collected in an effort to keep your most recent information as up-to-date as possible in our system. Please be sure to fill this form out **completely**. If you choose not to, we will assume that you desire to pay in full for services rendered today and that you plan on filing your own insurance claim.

Today's date: \_\_\_\_\_ Patient's full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

(please circle) MALE FEMALE Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M W D

Patient's Home Address (Street and/or Apt number): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_ Cell Phone/Mobile Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Emergency contact information: Name of person to contact in the event of an emergency: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone numbers: Home: \_\_\_\_\_ Other: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_ Policy holder name: \_\_\_\_\_

Policy holder date of birth: \_\_\_\_\_ Policy holder social security number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Policy Holder Employer: \_\_\_\_\_ Policy holder name: \_\_\_\_\_

Policy holder date of birth: \_\_\_\_\_ Policy holder social security number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Financial Information** Our billing policy is to collect all co-pay amounts at the time of service. If you have no insurance, full payment is expected at the time of service. We accept payment by cash, check, and Visa, Mastercard or Discover. If there is a problem with your insurance company or your bill, please contact us regarding the problem. Please do not ignore your bill as doing so may cause delinquency in your account and resulting in an aggressive collection effort.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. Should I fail to pay my bill, and collection efforts become necessary, I understand that I will be responsible for any and all charges, including by bill in full, collection fees, and attorney fees. I further authorize my medical information/records to be released to my insurance company or fiscal intermediary as a means to obtain payment and I hereby assign their payment to Family Wellness Group of Middle Tennessee, LLC for services rendered.

\_\_\_\_\_  
Signature of Person Financially Responsible Date

**IMPORTANT HEALTH HISTORY AND RELATIVE INFORMATION  
PLEASE COMPLETE THE ENTIRE FORM**

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**1. CHECK ANY OF THE FOLLOWING ILLNESSES THAT YOU OR A BLOOD RELATIVE HAVE HAD:**

<b>YOU</b>	<b>BLOOD RELATIVE</b>	<b>ILLNESS</b>	<b>WHO</b>
		AIDS	
		ANEMIA	
		ARTHRITIS/BONE/JOINT PROBLEMS	
		CANCER/TUMOR TYPE:	
		CHRONIC/RECURRENT HEADACHES	
		COLON PROBLEMS	
		DIABETES	
		EPILEPSY/SEIZURES	
		EYES/NOSE/EARS SINUS PROBLEMS	
		GENITAL WARTS	
		HEART ATTACK/HEART CONDITIONS AGE:                      DETAILS:	
		HERPES	
		HIGH BLOOD PRESSURE	
		JAUNDICE	
		LIVER/HEPATITIS/GALL BLADDER PROBLEMS	
		LUNG PROBLEMS/ASTHMA/EMPHYSEMA	
		MENINGITIS	
		MENSTRUAL PROBLEMS	
		NERVES/PSYCHIATRIC PROBLEMS	
		PASSING BLOOD IN STOOL	
		PNEUMONIA	
		PROSTATE PROBLEMS	
		RHEUMATIC PROBLEMS	
		STOMACH PROBLEMS/ULCERS	
		STROKE AGE:                      DETAILS:	
		TB	
		THROAT PROBLEMS	
		THYROID PROBLEMS	
		VENEREAL DISEASE	
		OTHER PERTINENT INFORMATION:	

**IMPORTANT HEALTH HISTORY AND RELATIVE INFORMATION  
PLEASE COMPLETE THE ENTIRE FORM**

2. PLEASE LIST ANY AND ALL TIMES THAT YOU HAVE EVER BEEN IN THE HOSPITAL FOR ANY MEDICAL TREATMENT. (WRITE NONE IF NON APPLICABLE)

SURGERIES YOU HAVE HAD:

3. PLEASE LIST ANY REGULAR PRESCRIPTIONS OR OVER THE COUNTER MEDICATIONS (AND THE DOSES) THAT YOU TAKE, OR HAVE TAKEN IN THE LAST TEN DAYS. (WRITE NONE IF NON APPLICABLE)
4. PLEASE LIST ANY MEDICATIONS OR OTHER ITEMS TO WHICH YOU ARE ALLERGIC TO, AND DESCRIBE THE REACTION YOU HAVE. (WRITE NONE IF NON APPLICABLE)

5.

DO YOU USE?	YES	NO	HOW MUCH?	FOR HOW LONG?
TOBACCO				
ALCOHOL				
CAFFEINE				
STREET DRUGS TYPE:				

6. WHAT IS YOUR OCCUPATION? \_\_\_\_\_

7. HAVE YOU EVER HAD A BLOOD TRANSFUSION?      YES      NO

8. LAST IMMUNIZATIONS: (PLEASE DATE IF KNOWN)

TETANUS \_\_\_\_\_

2ND MEASLES \_\_\_\_\_

HEPATITS B \_\_\_\_\_

PNEUMONIA \_\_\_\_\_

FLU \_\_\_\_\_

9. DO YOU HAVE A RELIGIOUS PREFERENCE?      YES      NO

IF YES, WHAT IS IT? \_\_\_\_\_

10. IF YOU ARE A FEMALE OF CHILDBEARING AGE, WHAT TYPE OF BIRTH CONTROL DO YOU USE? (SKIP THIS QUESTION IF NON APPLICABLE)

11. LIST ANY DISEASES YOU ARE CURRENTLY OR HAVE EVER BEEN TREATED FOR:

**Family Wellness Group of Middle Tennessee, LLC**

Patient consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Family Wellness Group of Middle Tennessee, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPHO). (The Notice of Privacy Practices provided by Family Wellness Group of Middle Tennessee, LLC describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Wellness Group of Middle Tennessee, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Wellness Group of Middle Tennessee, LLC, 107 Glen Oak Blvd., Suite 201, Hendersonville, TN 37075.

With this consent, Family Wellness Group of Middle Tennessee, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Family Wellness Group of Middle Tennessee, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Family Wellness Group of Middle Tennessee, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements. I have the right to request that Family Wellness Group of Middle Tennessee, LLC restrict how it uses or discloses my PHI to carry out TPHO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Family Wellness Group of Middle Tennessee, LLC to use and disclose my PHI to carry out TPHO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Wellness Group of Middle Tennessee, LLC may decline to provide treatment to me.

Signed by:

I, \_\_\_\_\_ acknowledge receipt of Family Wellness Group of Middle Tennessee, LLC, notice of Privacy Practices this date \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Legal Guardian, if applicable

**Family Wellness Group, P.C.**  
107 Glen Oak Blvd Suite 201  
(615) 822-2400 Fax (615) 822-9641

**Authorization to Release Medical Records/Information**

**Patient's Name:** \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Physician to provide records:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

**Person/facility to receive records:** FAMILY WELLNESS GROUP Phone: (615) 822-2400

Address: 107 GLEN OAK BLVD. SUITE 201

City, State, and Zip: HENDERSONVILLE, TN 37075

**If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.**

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials

\_\_\_\_\_ Substance abuse, if any \_\_\_\_\_ AIDS/HIV, if any

\_\_\_\_\_ Psychological or psychiatric conditions, if any

Other (please specify): \_\_\_\_\_

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name (print):

Person authorized to sign for patient:

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Relationship to patient: