Welcome to our practice

Thank you for selecting our health care team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Name _____
Last First Middle

Birth Date ____/____/____ Age _____ Sex: M F Marital Status: Married Single Widowed Divorced

Social Security # _____-_____-_____ Employer Name _____

Home Address _____ Employer Address _____
Street Street

_____ _____
City, State & Zip Code City, State & Zip Code

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

RESPONSIBLE PARTY INFORMATION (If patient is a minor)

Responsible Party Name _____ Relationship to Patient _____

Address _____ Phone # (_____)_____

SPOUSE INFORMATION

Spouse Name _____ Social Security # _____-_____-_____

Employer _____ Employer Address _____

Birth Date _____/_____/_____ Work Phone (_____)_____ Cell Phone (_____)_____

MEDICAL INSURANCE INFORMATION (Please provide insurance card to receptionist for a photocopy.)

Insurance Policy (Primary) Insurance Company Name _____

Address _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____/_____/_____ Social Security # _____-_____-_____

Group # _____ Policy ID# _____

Person to Notify in Case of Emergency: _____ Relationship to Patient _____

Phone # (_____) _____ Address _____

Referred by: _____

AUTHORIZATION (PLEASE SIGN) I hereby authorize the release of any medical information necessary to process insurance claims and further authorize payment of medical benefits to my physician in the event he/she files insurance for services rendered. I understand I am financially responsible for all charges not covered by my insurance company. I also understand that I will be responsible for all collection fees, attorney fees & court costs should my account be turned out for collections.

X_____ _____
Patient or authorized person's signature Date

Acct # _____

DATE_____ DATE OF BIRTH_____

NAME_____ SEX_____ AGE_____

MARITAL STATUS S D W M

ALLERGIES:_____

_____

CURRRENT MEDICATIONS:_____

_____

RECURRENT PROBLEMS_____

_____

PERSONAL/FAMILY HISTORY DATE YES/NO SELF/FAMILY MEMBER

ABDOMINAL BLEEDING_____
ALLERGIES_____
ANEMIA_____
ASTHMA_____
BLEEDING DISEASES_____
BLOOD IN STOOL_____
BLOOD IN URINE_____
CANCER_____
DEPRESSION_____
DIABETES_____
ENLARGED HEART_____
GLAUCOMA_____
HEADACHES_____
HEART DISEASE_____
HEPATITIS_____
HIGH BLOOD PRESSURE_____
KIDNEY INFECTON_____
STROKE_____
T.B._____
THYROID DISEASE_____
OTHER_____

_____

ANY OTHER INFORMATION THAT YOU FEEL IS IMPORTANT FOR THE PHYSICIAN TO BE AWARE OF_____

_____

_____
SIGNATURE

West Wilson Family Practice Center, P.C.

Ph:615-758-5672 Fax: 615-758-5609

Please help us with our transition from paper to electronic by bringing this form back as soon as possible.

Name: _____
Date of Birth: _____
Allergies:

_____
_____
_____
_____

Medications:

Medicine	Dose	How often	Prescribing Doctor

Past Surgical History:

Family Medical History:

Cancer: Yes / No Type: _____
Family Member: _____

Diabetes: Yes / No Family Member: _____

Hypertension: Yes / No Family Member: _____

Heart: Yes / No Family Member: _____

Thyroid: Yes / No Family Member: _____

Kidney: Yes / No Family Member: _____

Stroke: Yes / No Family Member: _____

Personal Medical History:

Illness	Date Diagnosed	Still Under Treatment	
Example:			
Colon Cancer	Dec 2010	Yes / No	Doctor's Name

Social History:

Are you a smoker? Yes / No
Past or Present: _____
How often: _____

Do you drink alcohol? Yes / No
Past or Present: _____
How much/ often: _____

Do you exercise? Yes / No
How often: _____

Do you use street drugs? Yes / No
Past or Present: _____
How often: _____

Miscellaneous:

Is there any other information that you feel is important for the Physician to be aware of?

_____
_____
_____
_____

West Wilson Family Practice Center, P.C.

Bernard Pare', M.D., Sohpie Lagueux, M.D., Cameron Shearer, M.D.
3500 N. Mt. Juliet Road, Ste 201, Mt. Juliet, Tennessee 37122
Phone: 615-758-5672 Fax: 615-758-5609

Cancellations of Appointments/No-Show

To All Our Patients:

When you do not show up for a scheduled appointment or when you cancel at the last minutes you deny other patients the opportunity to be seen. It is very important that you cancel a regular appointment at least **24 hours** prior to the appointment and at least **48 hours** before a Complete Physical Exam.

There is a $35.00 fee for no shows on a regular appointment and a $75.00 fee for a no show on a Complete Physical Exam.

_____ _____

Signature Date

West Wilson Family Practice Center, P.C.

Bernard Pare', M.D., Sohpie Lagueux, M.D., Cameron Shearer, M.D.
3500 N. Mt. Juliet Road, Ste 201, Mt. Juliet, Tennessee 37122
Phone: 615-758-5672 Fax: 615-758-5609

Notice of Our Privacy Practice

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____

Signature _____

Date _____

WEST WILSON FAMILY PRACTICE

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

_____ D.O.B

Patient Name (please print)

has requested confidential communication of protected Health Information.

Designated method of releasing information:

_____ _____

Name Telephone #

_____ _____

Name Telephone #

_____ _____

Name Telephone #

Address to mail results (if needed):

_____

Name

_____

Address

_____

City, State, Zip

_____

Telephone # (Messages could be left at this #)

_____ You may contact me at work Work # _____

X _____ _____

Patients Signature Date