



AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Social Security: _____ Phone: _____

Persons/organizations providing the information:

Name: _____

Address: _____

City, State, Zip: _____

Organizations receiving the information:

Williamson Medical Group

4323 Carothers Parkway, Suite 505

Franklin, TN 37067 Fax: 615-435-7352

What is the purpose of the use or disclosure? **At the request of the Individual**

Section B: Must be completed only if the healthcare provider has requested the authorization

- Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ___ Yes No
- Information to be disclosed: The information to be disclosed includes only those items checked below, with respect to services provided on or around NEXT APPOINTMENT DATE.

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Lab/Pathology results	<input type="checkbox"/> HIV/AIDS test results
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Diagnostic reports	<input type="checkbox"/> Alcohol/Drug treatment
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> ER visit	<input type="checkbox"/> Other (specify): _____

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the physician declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by sending a written notice to the Medical Group. However, the revocation will not have any effect on any uses or disclosures the Medical Group may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed. I understand that I may refuse to sign this Authorization and that the Medical Group will not condition treatment on whether I sign this Authorization.

I certify that I am:

- The patient and the identification that I provided is true and correct.
- The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
My relationship to the patient is that of: _____

Signature: _____ Date: _____

Print Name: _____

WMG USE ONLY:

Date Received:	
How was identity verified:	Copy Made? <input type="checkbox"/> Yes <input type="checkbox"/> No
How was authority verified:	Copy Made? <input type="checkbox"/> Yes <input type="checkbox"/> No
Completed by: _____	Date: _____



To help us meet your health care needs, please complete this form in ink. If you need assistance, please let us know.

PATIENT INFORMATION

Name: Last First Middle Initial

Sex: M F DOB: Social Security Number:

Address: Street or P.O. Box City State Zip Code

Home Phone: Cell/Other Phone: Work Phone:

E-mail:

Employer: Referred By:

Emergency Contact: Emergency Phone:

Marital Status: Single Married Divorced Widowed If Married, Spouse's Name

INSURANCE INFORMATION

Person responsible for bill:

Primary Insurance: Subscriber: (Name of insurance) (Person who carries insurance)

Relationship to Patient: Self Spouse Child Sex: M F DOB:

Subscriber's Social Security Number: Subscriber's Employer:

Secondary Insurance: Subscriber: (Name of insurance) (Person who carries insurance)

Relationship to Patient: Self Spouse Child Sex: M F DOB:

Subscriber's Social Security Number: Subscriber's Employer:

I understand and agree that I will be responsible for payment of any and all services rendered by Williamson Medical Group and authorize the release of any diagnosis or records of treatment to my insurance(s) to support any medical claims made. I also authorize my insurance(s), Medicare/Medigap, to make payment directly to Williamson Medical Group for services rendered. I understand that it is my responsibility to know my insurance benefits, and that I will be responsible for payment of all services rendered that are not covered. I agree to pay each office visit co-payment at the time of service, in accordance with my insurance company contract. Should my account be forwarded to an outside collection agency, I agree to pay all collection/attorney fees incurred. I certify that the information above is true and correct. *I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. *I understand it is my responsibility to notify the practice of any individuals with whom I want my Private Health Information discussed and my responsibility to update this information if it changes.

Signature: Date:



PATIENT PERMISSION FORM

I, _____, give Williamson Medical Group permission to
(please check all that apply):

Call my: Home Phone _____
 Cell Phone _____
 Work Phone _____

Leave a message on my: Home Phone
 Cell Phone
 Work Phone

Regarding: Appointments
 Medical Conditions
 Lab work, test results, etc.

May discuss my medical condition with:

Other preferences: _____

Patient or Legal Guardian's Signature: _____ Date: _____



PATIENT HEALTH HISTORY FORM

To help us meet your health care needs, please complete this form in ink. If you need assistance, please let us know.

Name: _____ Date of Birth: _____ Today's Date: _____

PERSONAL MEDICAL HISTORY (CHECK ALL THAT APPLY)

Allergy <input type="checkbox"/>	Colon or Bowel Disease (including polyps) <input type="checkbox"/>
Asthma <input type="checkbox"/>	Kidney Problem (including stones) <input type="checkbox"/>
COPD/Emphysema <input type="checkbox"/>	Gynecologic Problems (including fibroids or endometriosis) <input type="checkbox"/>
Atrial Fibrillation <input type="checkbox"/>	Prostate Problems <input type="checkbox"/>
Heart Murmur as an Adult <input type="checkbox"/>	Migraine Headaches <input type="checkbox"/>
Heart Disease/Heart Attack <input type="checkbox"/>	Stroke <input type="checkbox"/>
Congestive Heart Failure <input type="checkbox"/>	Seizures/Epilepsy <input type="checkbox"/>
High Cholesterol <input type="checkbox"/>	Arthritis <input type="checkbox"/>
High Blood Pressure <input type="checkbox"/>	Rheumatoid Arthritis or Lupus <input type="checkbox"/>
History of Cancer or Tumor <input type="checkbox"/>	Gout <input type="checkbox"/>
Thyroid Condition (hypo or hyper) <input type="checkbox"/>	Anemia <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Blood Clots <input type="checkbox"/>
Osteoporosis <input type="checkbox"/>	Sleep Apnea <input type="checkbox"/>
Bone Fractures <input type="checkbox"/>	Alcohol/Drug Problem <input type="checkbox"/>
Glaucoma <input type="checkbox"/>	Anxiety or Panic Attacks <input type="checkbox"/>
Acid Reflux or Heartburn <input type="checkbox"/>	Depression <input type="checkbox"/>
Hepatitis <input type="checkbox"/>	Bipolar Disease <input type="checkbox"/>
Liver Cirrhosis <input type="checkbox"/>	Other: _____
Stomach or Duodenal Ulcer <input type="checkbox"/>	
Irritable Bowel Disease <input type="checkbox"/>	



Name: _____ Date of Birth: _____ Today's Date: _____

PERSONAL SURGICAL HISTORY (CHECK ALL THAT APPLY)

- | | |
|---|---|
| Weight Loss Surgery <input type="checkbox"/> | Hip Surgery <input type="checkbox"/> |
| Appendix Removed <input type="checkbox"/> | Hysterectomy (ovaries removed) <input type="checkbox"/> |
| Back Surgery <input type="checkbox"/> | Hysterectomy (ovaries left) <input type="checkbox"/> |
| Prostate Surgery <input type="checkbox"/> | Knee Surgery <input type="checkbox"/> |
| Breast Surgery <input type="checkbox"/> | Neck Surgery <input type="checkbox"/> |
| Coronary Bypass <input type="checkbox"/> | Tubal Ligation <input type="checkbox"/> |
| Coronary Stenting <input type="checkbox"/> | Spleen Removed <input type="checkbox"/> |
| Heart Surgery (other than bypass/stents) <input type="checkbox"/> | Other: _____ |
| Gallbladder Removal <input type="checkbox"/> | |

MEDICATIONS

Name	Dose	Directions

DRUG OR FOOD ALLERGIES

Drug Name	Reaction

No known allergies



Name: _____ Date of Birth: _____ Today's Date: _____

FAMILY HISTORY (CHECK ALL THAT APPLY)

	Mother	Father	Sister	Brother
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PREVENTIVE CARE (INDICATE DATES)

Pneumonia Vaccine: _____ Colonoscopy: _____ Bone Density Scan: _____
 Tetanus Vaccine: _____ Pap Smear: _____ PSA/Prostate Exam: _____
 Shingles Vaccine: _____ Mammogram: _____

OTHER HEALTH ISSUES

Tobacco Use: Never Yes No
 • Current Smoker: Yes packs/day _____ # of years _____
 • Former Smoker: Yes # of years smoked _____ quit date _____
 • Current Chewing Tobacco User: Yes # of years _____
 • Former Chewing Tobacco User: Yes # of years used _____ quit date _____

Alcohol Use: Yes No type of drink _____ # of drinks/week _____

Drug Use:
 • Do you use marijuana or recreational drugs? Yes No
 • Have you ever used needles to inject drugs? Yes No

Do you have an Advance Directive for Health Care (ADHC)? Yes No
 Do you have a Durable Power of Attorney for medical decision-making? Yes No

Name: _____ Date of Birth: _____ Today's Date: _____

INDICATE IF YOU'VE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE PAST MONTH (CHECK ALL THAT APPLY):

<p>General</p> <p>Fatigue <input type="checkbox"/></p> <p>Weight Gain <input type="checkbox"/></p> <p>Weight Loss <input type="checkbox"/></p> <p>Skin</p> <p>New/Changing Moles <input type="checkbox"/></p> <p>Rashes <input type="checkbox"/></p> <p>Head/Eyes/Ears/Nose/Throat</p> <p>Eye Pain <input type="checkbox"/></p> <p>Visual Disturbances <input type="checkbox"/></p> <p>Hearing Loss <input type="checkbox"/></p> <p>Seasonal Allergies <input type="checkbox"/></p> <p>Respiratory</p> <p>Persistent Cough <input type="checkbox"/></p> <p>Snoring <input type="checkbox"/></p> <p>Wheezing <input type="checkbox"/></p> <p>Shortness of Breath <input type="checkbox"/></p> <p>Cardiovascular</p> <p>Chest Pain <input type="checkbox"/></p> <p>Fainting Spells <input type="checkbox"/></p> <p>Palpitations <input type="checkbox"/></p> <p>Swollen Feet/Ankles <input type="checkbox"/></p>	<p>Gastrointestinal</p> <p>Abdominal Pain <input type="checkbox"/></p> <p>Black Stools <input type="checkbox"/></p> <p>Bloody Stools <input type="checkbox"/></p> <p>Constipation <input type="checkbox"/></p> <p>Diarrhea <input type="checkbox"/></p> <p>Heartburn <input type="checkbox"/></p> <p>Nausea/Vomiting <input type="checkbox"/></p> <p>Urinary</p> <p>Blood in Urine <input type="checkbox"/></p> <p>Burning <input type="checkbox"/></p> <p>Increased Frequency <input type="checkbox"/></p> <p>Bladder Leakage <input type="checkbox"/></p> <p>Musculoskeletal</p> <p>Joint Pain <input type="checkbox"/></p> <p>Joint Stiffness <input type="checkbox"/></p> <p>Joint Swelling <input type="checkbox"/></p> <p>Muscle Pain <input type="checkbox"/></p> <p>Neurological</p> <p>Memory Loss <input type="checkbox"/></p> <p>Headaches <input type="checkbox"/></p> <p>Numbness <input type="checkbox"/></p>	<p>Seizures <input type="checkbox"/></p> <p>Tremors <input type="checkbox"/></p> <p>Weakness <input type="checkbox"/></p> <p>Psychiatric</p> <p>Anxiety <input type="checkbox"/></p> <p>Depression <input type="checkbox"/></p> <p>Insomnia <input type="checkbox"/></p> <p>Blood/Lymph Nodes</p> <p>Easy Bleeding <input type="checkbox"/></p> <p>Easy Bruising <input type="checkbox"/></p> <p>Enlarged Glands <input type="checkbox"/></p> <p>Females Only</p> <p>Date of Last Period: _____</p> <p>Increased Bleeding <input type="checkbox"/></p> <p>Irregular Periods <input type="checkbox"/></p> <p>Pelvic Pain <input type="checkbox"/></p> <p>Vaginal Discharge <input type="checkbox"/></p> <p>Breast Pain/Lumps <input type="checkbox"/></p> <p>Hot Flashes <input type="checkbox"/></p> <p>Males Only</p> <p>Erectile Dysfunction <input type="checkbox"/></p>
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FOR WOMEN ONLY

Obstetric History:

Have you ever been pregnant? Yes No

Are you currently pregnant? Yes No