WILLIAMSON
MEDICAL GROUP

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

1. 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 _X_ No
2. 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.

☐ Entire Medical Record	☐ Lab/Pathology results	☐ HIV/AIDS test results
☐ Discharge summary	☐ Diagnostic reports	☐ Alcohol/Drug treatment
☐ History and physical exam	☐ ER visit	☐ 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? ☐ Yes ☐ No
How was authority verified:	Copy Made? ☐ Yes ☐ No
Completed by: Date:	

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MEDICAL GROUP

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: _____

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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: _____

WILLIAMSON
MEDICAL GROUP

GASTROENTEROLOGY 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)

- Acid Reflux or Heartburn ☐
- Alcohol/Drug Problem ☐
- Allergy ☐
- Anemia ☐
- Anxiety or Panic Attacks ☐
- Arthritis ☐
- Atrial Fibrillation ☐
- Asthma ☐
- Bipolar Disease ☐
- Blood Clots ☐
- Celiac Sprue ☐
- Colon Cancer ☐
- Congestive Heart Failure ☐
- COPD/Emphysema ☐
- Depression ☐
- Diabetes ☐
- Diverticulosis ☐
- Glaucoma ☐
- Gout ☐
- Gynecologic Problems (including fibroids or endometriosis) ☐
- Heart Disease/Heart Attack ☐
- Hepatitis ☐
- High Cholesterol ☐
- High Blood Pressure ☐
- History of Cancer or Tumor ☐
- Inflammatory Bowel Disease (ulcerative colitis, Crohn's) ☐
- Irritable Bowel Syndrome ☐
- Kidney Problem (including stones) ☐
- Liver Cirrhosis ☐
- Migraine Headaches ☐
- Osteoporosis ☐
- Rheumatoid Arthritis or Lupus ☐
- Seizures/Epilepsy ☐
- Sleep Apnea ☐
- Stomach or Duododenal Ulcer ☐
- Stroke ☐
- Thyroid Condition (hypo or hyper) ☐
- Other:

Last Colonoscopy Year: _____ Polyps Found (circle one): Y or N

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

PERSONAL SURGICAL HISTORY (CHECK ALL THAT APPLY)

- Weight Loss Surgery ☐
- Appendix Removed ☐
- Back Surgery ☐
- Prostate Surgery ☐
- Breast Surgery ☐
- Coronary Bypass ☐
- Coronary Stenting ☐
- Heart Surgery (other than bypass/stents) ☐
- Gallbladder Removal ☐
- Hip Surgery ☐
- Hysterectomy (ovaries removed) ☐
- Hysterectomy (ovaries left) ☐
- Knee Surgery ☐
- Neck Surgery ☐
- Tubal Ligation ☐
- Spleen Removed ☐
- Colon Surgery ☐

If yes, specify: _____

MEDICATIONS

Name	Dose	Directions

DRUG OR FOOD ALLERGIES

Drug Name	Reaction

☐ No known allergies

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

FAMILY HISTORY (CHECK ALL THAT APPLY)

	Mother	Father	Sister	Brother
Alcohol Problem	☐	☐	☐	☐
Alzheimer Disease	☐	☐	☐	☐
Aortic Aneurysm	☐	☐	☐	☐
Bleeding/Clotting Disorder	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐
age diagnosed:	_____	_____	_____	_____
Depression/Anxiety	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐
Gastric Cancer	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Liver Cancer	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐

FOR IBD PATIENTS - PREVENTIVE CARE (INDICATE DATES)

Pneumonia Vaccine: _____ Bone Density Scan: _____ Flu Shot: _____
Tetanus Vaccine: _____ Pap Smear: _____ Hep A: _____
Shingles Vaccine: _____ Mammogram: _____ Hep B: _____

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

WILLIAMSON MEDICAL GROUP

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):

General
- Fatigue ☐
- Weight Gain ☐
- Weight Loss ☐

Skin
- New/Changing Moles ☐
- Rashes ☐

Head/Eyes/Ears/Nose/Throat
- Eye Pain ☐
- Visual Disturbances ☐
- Hearing Loss ☐
- Seasonal Allergies ☐

Respiratory
- Persistent Cough ☐
- Snoring ☐
- Wheezing ☐
- Shortness of Breath ☐

Cardiovascular
- Chest Pain ☐
- Fainting Spells ☐
- Palpitations ☐
- Swollen Feet/Ankles ☐

Gastrointestinal
- Abdominal Pain ☐
- Black Stools ☐
- Bloody Stools ☐
- Constipation ☐
- Diarrhea ☐
- Heartburn ☐
- Nausea/Vomiting ☐

Urinary
- Blood in Urine ☐
- Burning ☐
- Increased Frequency ☐
- Bladder Leakage ☐

Musculoskeletal
- Joint Pain ☐
- Joint Stiffness ☐
- Joint Swelling ☐
- Muscle Pain ☐

Neurological
- Memory Loss ☐
- Headaches ☐
- Numbness ☐
- Seizures ☐
- Tremors ☐
- Weakness ☐

Psychiatric
- Anxiety ☐
- Depression ☐
- Insomnia ☐

Blood/Lymph Nodes
- Easy Bleeding ☐
- Easy Bruising ☐
- Enlarged Glands ☐

Females Only
- Date of Last Period: _____
- Increased Bleeding ☐
- Irregular Periods ☐
- Pelvic Pain ☐
- Vaginal Discharge ☐
- Breast Pain/Lumps ☐
- Hot Flashes ☐

Males Only
- Erectile Dysfunction ☐

FOR WOMEN ONLY

Obstetric History:

Have you ever been pregnant? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No