NOLENSVILLE FAMILY MEDICINE
JOHN R. THOMPSON, M.D.

PATIENT INFORMATION (Please Print)

Patient Legal Name: _____ ☐ Male ☐ Female
First M.I. Last

Name Preferred: _____ Birth Date: _____ SSN#: ___-___-____

Address: _____ City, State, Zip: _____

Employer: _____ Occupation: _____

Patient Phone # (Home): _____ (Cell) _____ (Work): _____

To Activate Patient Portal Please List Non-Work Related Email Address _____

Language _____ Race: _____ Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin

Primary Pharmacy: _____ Address: _____ Phone # _____

SPOUSE INFORMATION

Name: _____ Birth Date: _____ SSN# ___-___-____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____ Listed on HIPAA ☐ Yes ☐ No

RESPONSIBLE PARTY (Person Statements Will Be Addressed To)

Name: _____ Relation: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
Name of Insurance Company	Name of Insurance Company
Policy Holder	Policy Holder
Date of Birth (Policy Holder) SSN (Policy Holder)	Date of Birth (Policy Holder) SSN (Policy Holder)
Relationship To Patient	Relationship To Patient
Subscriber ID#	Subscriber ID#
Group #	Group #

AUTHORIZATION OF RELEASE

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third-party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual charge for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

_____

Signature of Patient (Parent or Guardian of Minor) Date

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JOHN R. THOMPSON, MD

HIPAA RELEASE FORM DOCUMENT

I (please print) _____ have received and read the Nolensville Family Medicine Notice of Privacy Practices.

Patient Name (please print)_____ Date of Birth _____

_____
Patient Signature or Parent / Legal Guardian if Under 18 Years Old

_____ Date_____
Witness Signature

I authorize this organization to discuss my medical condition and information with the following:

Name	Relation	Phone Number

I authorize Nolensville Family Medicine to leave a message regarding my medical information on the following voicemail:

Cell _____ Other_____

☐ Checking this box grants this organization permission to view my prescription history from external sources.

Nolensville Family Medicine

John R. Thompson M.D. PLLC

We would like to take this opportunity to thank you for choosing Nolensville Family Medicine for your medical care. While our primary concern is treating you and your family's healthcare needs, we understand that you may have concerns regarding your insurance and financial obligations.

We ask that you understand your benefits and services that are covered or not covered by your insurance. Although we accept most commercial insurances, not all insurances have the same benefits. Benefits can vary from patient to patient depending on the plan you are covered on.

Below is a summary of our financial policy. Please initial beside each statement to indicate your understanding of the statement.

1. You will be asked to pay your Co-Pay, Co-Insurance, and/or Deductible at the time of each visit.
   Initial _____

2. At every visit you will be asked for your insurance information, if you fail to supply the correct or current insurance information at the time of your visit, the balance will be forwarded to you for payment. We do not refile insurance claims. You will be responsible for the balance. We will provide you the information you need to file the insurance on your own.
   Initial _____

3. The payment received varies by insurance company. It is the responsibility of the patient to pay any outstanding balance that remains. We will send you a statement after your insurance has paid.
   Initial _____

4. Covered and Non-Covered services differ from plan to plan. We ask that you review and understand your benefits and policies regarding what services are covered and what services are not covered. If a procedure or service is not covered, you will be billed for that amount directly.
   Initial _____

5. Some insurance companies require that lab work be sent to a specific laboratory. It is your responsibility to know where your labs should be sent for correct billing.
   Initial _____

6. Accounts that are delinquent and are sent out to our collection agency will be assessed a 20% collection fee. You will be responsible for all attorney fees and court cost associated with these collections. Nolensville Family Medicine uses Nashville Adjustment Bureau for all delinquent accounts. Please be aware that if your account is turned out to our collection agency this will negatively affect your credit rating.
   Initial _____

7. If you make an appointment and fail to show for that appointment, there will be a $35.00 charge added to your account. You will be asked for that balance before your next appointment.
   Initial _____

8. If you have a returned check, you will incur a $25.00 returned check charge on the account. You will no longer be able to write a check at our office if this occurs.
   Initial _____

Please remember it is your responsibility to understand your insurance benefits and we will be glad to work with you and your insurance company to ensure appropriate payment for your medical charges.

I have read the above and understand my obligations. This will be a one time authorization, and will be kept on file.

_____

Patient Name (Please print)

_____

Signature of Patient (Guarantor if under the age of 18) Date

_____

Witness Date

Nolensville Family Medicine
Patient History (age 12+)

Name _____ **Date of Birth** _____ **Date** _____

Past Medical History:

List all allergies and meds you cannot take with reaction to each.

_____
_____
_____
_____
_____

List all fractures and other pertinent injuries, with dates.

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

List all of your medications with dosage of each.
Please include any over-the-counter medications.

_____
_____
_____
_____
_____
_____
_____
_____

List all surgeries and other hospitalizations with diagnoses and date of each.
Include births (vaginal or C-Section).

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Chicken Pox ..... Yes Date_____
Pneumonia ..... Yes Date(s)_____
Infectious Mono ..... Yes Date_____
Positive TB Test ..... Yes Year of Onset_____
AIDS or HIV+ ..... Yes Year of Onset_____
Rheumatic Fever ..... Yes Date_____
Heart Attack ..... Yes Date(s)_____
Congestive Heart Failure ..... Yes Year of Onset_____
High Blood Pressure ..... Yes Year of Onset_____
Other Heart Disease ..... Yes Type_____ Year of Onset_____
High Cholesterol ..... Yes Year of Onset_____
Mitral Valve Prolapse ..... Yes Year of Onset_____
Diabetes Mellitus ..... Yes Type_____ Year of Onset_____
Thyroid Disease ..... Yes Type_____ Year of Onset_____
Tuberculosis ..... Yes Date_____
Asthma ..... Yes Year of Onset_____
Breast Cancer ..... Yes Year of Onset _____
Colon Cancer ..... Yes Year of Onset _____
Prostate Cancer ..... Yes Year of Onset _____
Skin Cancer ..... Yes Type(s)_____ Date(s)_____
Other Type Cancer ..... Yes Type_____ Date_____
Anemia ..... Yes Type_____ Date_____
Bleeding Tendency ..... Yes Year of Onset_____

Migraine Headaches ..... Yes Year of Onset_____
Stroke ..... Yes Date(s)_____
Gout ..... Yes Year of Onset_____
Arthritis ..... Yes Type_____ Year of Onset_____
Osteoporosis ..... Yes Year of Onset_____
Glaucoma ..... Yes Year of Onset_____
Chronic Back Trouble ..... Yes Year of Onset_____
Prostate Infections ..... Yes Date(s)_____
Enlarged Prostate ..... Yes Year of Onset_____
Recurrent UTI's ..... Yes Year of Onset_____
Kidney Stones ..... Yes Date(s)_____
Other Kidney Disease ..... Yes Type_____ Date_____
Stomach Ulcer or H.Pylori ..... Yes Date(s)_____
Viral Hepatitis ..... Yes Type(s)_____ Date_____
Colon Polyp(s) ..... Yes Date(s)_____
Venereal Disease ..... Yes Type(s)_____ Date(s)_____
Mental Illness ..... Yes Type_____ Date_____
Anxiety ..... Yes Year of Onset _____
Depression ..... Yes Year of Onset _____
Alcohol Problem ..... Yes Year of Onset_____
Drug Problem ..... Yes Drug(s)_____ Year of Onset_____
Epilepsy ..... Yes Year of Onset_____
Other Significant History_____

Family Medical History: Please include family member, for example, Father, Maternal Grandfather, Paternal Grandmother, etc.
Please include type of illness when applicable, for example, Type I or Type II Diabetes, Colon Cancer, etc.

High Cholesterol_____
Heart Disease_____
Heart Attack_____
High Blood Pressure_____
Diabetes Mellitus_____
Thyroid Disease_____
Obesity_____
Cancer_____
Anemia_____
Bleeding Tendency_____
Ulcer_____
Gallstones_____
Kidney Disease_____
Glaucoma_____

Tuberculosis_____
Allergies_____
Asthma_____
Chronic Lung Disease_____
Osteoporosis_____
Gout_____
Stroke_____
Migraine Headaches_____
Mental Illness_____
Depression_____
Anxiety_____
Alcohol Problem_____
Drug Problem_____
Other_____

Social History:

Occupation_____ Retired? Unemployed?
Religious Affiliation_____
Name of Church/Synagogue_____
Alcohol Use?..... Yes # of drinks per week_____
Tobacco Use?..... Yes # packs per day_____ Age Started_____

Education Level _____
Hobbies_____
Types of Pets_____
Lived Out of Country?.... Yes Locations_____
Comments_____

Nolensville Family Medicine
John R. Thompson M.D.

Patient Name _____ DOB: _____ Today's Date _____

In the past 12 months, have you experienced any of the following?

	Yes	No		Physician Comments
1			Significant Weight Changes	
2			Frequent Dizziness	
3			Visual Changes	
4			Hearing Changes	
5			Ringing in Ears	
6			Frequent Difficulty Sleeping	
7			Frequent Use of Over the Counter Sleep Aids	
8			Frequent Headaches	
9			Allergy Symptoms of Nose, Eyes or Ears	
10			Difficulty Chewing or Swallowing Food	
11			Frequent Indigestion	
12			Frequent Use of Over the Counter Antacids	
13			Frequent Use of Over the Counter Pain Relievers	
14			Change in Usual Bowel Habits	
15			Black Tarry Stools	
16			Blood in Stool	
17			Chalky White Stools	
18			Unexplained Abdominal Pain	
19			Unexplained Chest Pain	
20			Recurring Flutters in Chest (Palpitations)	
21			Unexplained Shortness of Breath	
22			Recurrent Joint Pain or Swelling	
23			Frequent Swelling of Hands or Legs	
24			Focal Weakness or Numbness	
25			Loss of Consciousness	
26			Frequent Difficulty Passing Urine	
27			Regularly Wake up at Night to Void Urine	
28			How Many Times?	
29			Worrisome Skin Lesions	
32			**MEN ONLY**	
33			Difficulty with Sexual Function	
36			**WOMEN ONLY**	
37			Heavy/Frequent of Irregular Vaginal Bleeding	
38			Abnormal Vaginal Discharge	
39			Vaginal Itching or Burning	
40			Do you Perform Self Breast Exams?	
41			Any Change is Self Breast Exam?	
42			Date of Last PAP Smear:	
43			Ever Had an Abnormal PAP Smear?	
44			Date of Last Mammogram:	
45			Total Number of Pregnancies:	
46			Total Number of Miscarriages/Abortions	
47			Total Number of Children:	
48			Did you Breastfeed your Children?	
49			Your Age at First Pregnancy:	
50			Age When Started Periods:	