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

NOLENSVILLE FAMILY MEDICINE
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
Pediatric Medical History
[For ages under 12]

Child's Name____________________________ **Birth date**____________________________

Past Medical History: Has your child ever had:

Condition			Condition		
Mumps, Measles	Yes	No	Croup	Yes	No
Chicken Pox	Yes	No	TB/ Lung Disease	Yes	No
Eczema/ Skin Problems	Yes	No	High Blood Pressure	Yes	No
Pneumonia	Yes	No	Kidney/ Bladder Problems	Yes	No
Asthma/ Wheezing	Yes	No	Sexually Transmitted Disease	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No
Hepatitis	Yes	No	Handicaps/ Disabilities	Yes	No
HIV/ AIDS	Yes	No	Diabetes	Yes	No
Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Abnormal Bleeding	Yes	No	Congenital Heart Defect	Yes	No
Allergies	Yes	No	Heart Murmur	Yes	No
Frequent Ear Infections	Yes	No	Convulsions/ Epilepsy	Yes	No
Frequent Colds or Sore Throats	Yes	No	Emotional Disorders or Suicide Attempts	Yes	No

Please list any hospitalizations, surgeries, trauma, and serious or unusual illnesses which your child has experienced.

Date **Hospitalization/Surgery/Trauma/Illness** **Hospital/ Physician's Name** **City, State**

____

____

____

____

List all food/drug/insect allergies with reaction to each.

____

____

____

____

List all current medications with dosage of each

____

____

____

____

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:

Child's Education Level ____________________
Religious Affiliation____________________
Name of Church/Synagogue____________________
Comments____________________

Hobbies____________________
Types of Pets____________________
Lived Out of Country?...Yes Locations____________________

____
Signature of Parent or Guardian

____
Date

Nolensville Family Medicine
Pediatric Review of Systems
[For ages under 12]

Child's Name________________________ **Birth date**_________________________

Review of Systems: Please circle any problems your child currently has or ever has had.

Thumb Sucking	Yes No	Toilet Training Problems	Yes No
Diarrhea or Constipation	Yes No	Dental Problems	Yes No
Irritable/ Temper Problems	Yes No	Bed Wetting	Yes No
Nightmare/ Sleep Problems	Yes No	Eye Problems	Yes No
Developmental Problems	Yes No	Speech Problems	Yes No
Has your child ever eaten dirt, paint, or plaster?	Yes No	Hearing Problems	Yes No
Does your child take vitamins, fluoride, iron or other supplements?	Yes No	Was your child born more than two weeks late or two weeks early?	Yes No
Feeding or Eating Problems	Yes No	Child's Weight at Birth:	Lbs. oz.
# of Meals each Day:		Type of Delivery:	Vaginal C-Section
# of Snacks each Day:		Was/ is child breast-fed? Age Discontinued: ________	Yes No
Does your child get along with other children?	Yes No	Did the mother use any cigarettes, alcohol, drugs, or medication during pregnancy?	Yes No
Is your child doing well in school/ daycare?	Yes No	Emotional Problems	Yes No
Discipline Problems	Yes No	Alcohol/ Drug Abuse	Yes No