ARMOUR FAMILY MEDICINE

728 WEST SHERROD AVE.
COVINGTON, TN 38019
901-476-7779 FAX 901-425-9777

Patient Registration Form

PATIENT INFORMATION

DATE	PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE HIGHLIGHTED AREAS MUST BY COMPLETED		
LAST NAME	FIRST NAME	MI	
STREET ADDRESS			
CITY	STATE	ZIP	
DRIVERS LICENSE	DATE OF BIRTH	SSN#	GENDER ☐ MALE ☐ FEMALE

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY RELATIONSHIP TOPATIENT ☐ SELF ☐ PARENT ☐ GUARDIAN	IF SELF IS CHECKED SKIP DOWN TO ADDITIONAL INFORMATION. Patients under the age of 18 will need a parent or guardian as responsible party otherwise the responsible party is self.		
LAST NAME	FIRST NAME	MI	
STREET ADDRESS			
CITY	STATE	ZIP	
DRIVERS LICENSE	DATE OF BIRTH	SSN#	GENDER ☐ MALE ☐ FEMALE

ADDITIONAL INFORMATION

PHONE	EMAIL ADDRESS		
PREFERRED PHARMACY			
EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER		
PREFERRED PROVIDER			
TRANSFER MEDICAL RECORDS FROM A PREVIOUS PROVIDER? ☐ YES ☐ NO	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED		
ALLOW APPOINTMENT REMINDERS? ☐ VOICE REMINDERS ☐ TEXT REMINDERS ☐ E-MAIL REMINDERS	ALLOW E-MAIL? ☐ YES ☐ NO	WOULD YOU LIKE PATIENT PORTAL ACCESS? ☐ YES ☐ NO	

PAYMENT METHOD

☐ PROMPT-PAY: Patients who pay in full at the time of service. Payment methods accepted cash, check, debit & creditcards

☐ PARTIAL PAYMENT: 50% due at the time of service and balance due with-in 30-days. Payment methods accepted cash, check, debit & credit cards

☐ INSURANCE: Provider will verify if your insurance is an accepted insurance. Patient is responsible for deductibles and copays at the time of service.

PRIMARY INSURANCE & SUBSCRIBER INFORMATION

INSURED RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN	IF SELF IS CHECKED, PATIENT INFORMATION ABOVE WILL BE USED. Please provide the Insurance and subscriber's information.		
INSURANCE COMPANY			
POLICY NUMBER	GROUP NUMBER	COPAY	
LAST NAME	FIRST NAME	MI	
STREET ADDRESS			
CITY	STATE	ZIP	
DRIVERS LICENSE	DATE OF BIRTH	SSN#	GENDER ☐ MALE ☐ FEMALE

SECONDARY INSURANCE & SUBSCRIBER INFORMATION

INSURED RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN	IF SELF IS CHECKED, PATIENT INFORMATION ABOVE WILL BE USED. Please provide the Insurance and subscriber's information.

INSURANCE COMPANY		
POLICY NUMBER	GROUP NUMBER	COPAY

LAST NAME	FIRST NAME	MI
STREET ADDRESS		

CITY	STATE	ZIP

DRIVERS LICENSE	DATE OF BIRTH	SSN#	GENDER ☐ MALE ☐ FEMALE

PROTECTED HEALTH INFORMATION

HIPAA PRIVACY AUTHORIZATION (optional)

PLEASE CHECK ONLY ONE	☐ I DO NOT AUTHORIZE ANYONE
	☐ I AUTHORIZE ARMOUR FAMILY MEDICINE TO USE AND DISCLOSE ALL THE PROTECTED HEALTH INFORMATION TO PERSONS LISTED

Names BELOW

_____

_____

I understand I may revoke the authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Armour Family Medicine 728 West Sherrod Ave., Covington, TN 38019. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain I effect until terminated by me in writing. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of theauthorization.

X

Signature of Patient or Responsible Party _____ Date

I hereby give my consent for Armour Family Medicine to use and disclose, protected health information about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Armour Family Medicine describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Armour Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Attn: Office Manager Armour Family Medicine 728 West Sherrod Ave., Covington, TN 38019. By signing this form, I am consenting to allow Armour Family Medicine to use and disclose my protected health information to carry out treatment, payment and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Armour Family Medicine may decline to provide treatment to me.

WOULD YOU LIKE A COPY OF THE NOTICE OF PRIVACY PRACTICES? ☐YES ☐NO

X _____ _____

Signature of Patient or Responsible Party Date

ARMOUR FAMILY MEDICINE
728 WEST SHERROD AVE.
COVINGTON, TN 38019
901-476-7779 FAX 901-425-9777

Medical Records Release Form

PATIENT INFORMATION			
LAST NAME	FIRST NAME		MI
STREET ADDRESS			
CITY		STATE	ZIP
PHONE	DATE OF BIRTH		

RESPONSIBLE PARTY INFORMATION			
RESPONSIBLE PARTY RELATIONSHIP TO PATIENT ☐SELF ☐PARENT ☐GUARDIAN	IF SELF IS CHECKED SKIP DOWN TO ADDITIONAL INFORMATION. Patients under the age of 18 will need a parent or guardian as responsible party otherwise the responsible party is self.		
LAST NAME	FIRST NAME		MI
STREET ADDRESS			
CITY		STATE	ZIP
PHONE	DATE OF BIRTH		

HEALTHCARE FACILITY INFORMATION			
NAME			
STREET ADDRESS			
CITY		STATE	ZIP
PHONE	FAX		
INFORMATION REQUESTED	☐ ALL MEDICAL RECORDS	☐ OTHER	
PURPOSE OF DISCLOSURE	☐ CHANGE OF PHYSICIAN	☐ OTHER	
PREFERRED METHOD OF DISCLOSURE	☐ COMPACT DISC	☐ PAPER	

MAIL OR FAX MEDICAL RECORDS TO:			
NAME ARMOUR FAMILY MEDICINE			
STREET ADDRESS 728 WEST SHERROD AVE.			
CITY Covington		STATE TN	ZIP 38019
PHONE 901-476-7779	FAX 901-425-9777		

I understand I may revoke the authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Armour Family Medicine, 728 West Sherrod Ave., Covington, TN 38019. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If fail to specify an expiration date, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Medical Information Release Form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization.

X _____ _____

Signature of Patient or Responsible Party — Date

Revised: 9/5/2018

ARMOUR FAMILY MEDICINE
MEDICATION LIST

Name:
Date of Birth:

Doctor:

Pharmacy:
Pharmacy Phone #:

Medication	Dosage	Date	Time	Remark

Patient Health Questionnaire-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Total point score:____ _

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Ouestionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284-1292

Source:
Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101-1110

ARMOUR FAMILY MEDICINE
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Assignment of Benefits & Simple Agreement Form

The patient authorizes ARMOUR FAMILY MEDICINE to deposit any checks received on their account, which happen to be paid in the patient's name.

In addition, the patient authorizes ARMOUR FAMILY MEDICINE to deposit any payments received in their name from any payer who submits payment to this clinic for services they have received by ARMOUR FAMILY MEDICINE.

Patient's Name:_____

Patient's Date of Birth:_____

Signature:_ X _____

Financial Agreement Form

The undersigned respectively agrees that, in consideration of services being rendered, payment of the account is guaranteed by the undersigned. The undersigned does understand that the obligation to pay the bill is the responsibility of the undersigned regardless of what the insurance may or not pay. This includes vaccines that are not covered by insurance. The undersigned further agrees, in the case of default of payment and/or should the account be turned over to collections, any attorney, court fees, and other expenses will be paid by the undersigned.

Signature: X _____

Date:_____

ARMOUR FAMILY MEDICINE
PATIENT HISTORY FORM

Patient's Name: _____ DOB_____ Today's Date: _____

Previous Physician's name: _____ Are your child's immunizations up to date? ☐Yes ☐No

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Asthma	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐COPD	☐Seizures	☐GERD
☐High blood pressure	☐Gout	☐Stroke	☐Liver problems / Hepatitis
☐Thyroid problems	☐Seasonal allergies	☐Headaches / Migraines	☐Arthritis
☐Anemia or blood problems	☐AIDS	☐Bipolar	☐Cancer
☐Shortness of breathe	☐Ear problems	☐Depression / Anxiety	☐ADD/ADHD

Please describe any current or past medical treatment not listed above

_____

_____

_____

_____

Have you ever been hospitalized? ☐Yes ☐No If yes, for what? _____

Have you ever had : (circle) Measles Mumps Chicken Pox Scarlet Fever Whooping Cough

Please list your past surgeries—surgeries include: Tubal Ligation, C-Sections, Vasectomy, Gallbladder Removal, Appendectomy, Tonsils Removed, Heart Bypass, Heart Stents, Ear Tube Placement, Cataracts, Hysterectomy, Hernia, Back, Neck, etc....

_____

_____

Allergies

Food or Medicines—Please List:_____

Social and Preventive History

Do you currently use tobacco?	☐Yes ☐No	How many packs per day? _____
Do you currently use any drugs?	☐Yes ☐No	Marijuana- Cocaine- Meth- PCP- Heroin- Other:_____
Do you drink alcohol, beer, or wine?	☐Yes ☐No	How many drinks per week? _____
Do you drink caffeine?	☐Yes ☐No	How many drinks per week? _____
Do you exercise?	☐Yes ☐No	
Do you wear a seatbelt?	☐Yes ☐No	

Family History

Has any member of your family (including children and parents) had any of the following illnesses:

☐Heart disease / Murmur / Angina	☐Diabetes	☐Thyroid problems	☐Stroke
☐High cholesterol	☐Cancer	☐Arthritis	☐Headaches / Migraines
☐High blood pressure	☐Liver problems / Hepatitis	☐Seizures	

Physical History

Date of last physical;_____ Last eye exam_____ Last Dental Exam_____

Females Only: Last pap smear_____ History of Abnormal pap? ☐Yes ☐No Last period:_____

Pregnancies: Total:_____ Delivery: Vaginal or C-Section Miscarriage_____ Abortion _____Stillborn _____

ARMOUR FAMILY MEDICINE

Advance Directive and Wills

Name: _____ Date:_____

Do you have a Will? □Yes □No

Do you have a Living Will? □Yes □No

Do you have an Advance Directive? □Yes □No

_____

Signature of patient or patient representative

_____

Witness Signature (Clinical Staff)

_____

Provider Signature

Please provide a copy of any Wills or Advance Directives you may have.

Armour Family Medicine PLLC

728 West Sherrod Ave.

Covington, TN 38019

Phone: 901-476-7779 Fax: 901-425-9777

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

Place for our office to get records FROM. Name : _____

Address: _____

Phone #: _____ Fax #: _____

to release healthcare information of the patient named above to:

Name: Armour Family Medicine, PLLC

Address: 728 West Sherrod Ave.

City: Covington State: TN Zip Code: 38019

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Signature of Guardian/Representative: _____ Relationship to Patient: _____