REGISTRATION FORM (please fill out COMPLETELY)

Name_____ **Date**_____
(First, Middle and Last)

Address_____ **City, State, Zip**_____

Home Phone:_____ **Cell Phone:**_____

E-Mail Address_____

Date of Birth_____ **Social Security Number**_____

(Circle one for each category) ***Marital Status*** **S M D W P ~~** ***Gender*** **M F N**

Race **– Black Hispanic White Other Prefer not to answer**

Preferred Pharmacy_____ **Address**_____

Emergency Contact **Relationship** **Home Phone#**

Primary Insurance Company_____

Secondary Insurance Company_____

Please provide the front desk staff member with your insurance card to scan into your chart.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dayspring Family Care, PLLC or insurance company to release any information required to process my claims. I also acknowledge receipt of privacy notices.

_____ **Date**_____
Patient/Guardian Signature

Name(s) of family members who are patients at Dayspring Family Care, PLLC.

Dayspring
Family Care
PLLC

INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make your own health care decisions.

You can also leave advance direction about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and are no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please feel free to ask your health provider, hospital, social worker or attorney.

It is our policy to honor our patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care decisions in order to receive care at this facility.

DO YOU HAVE A LIVING WILL?	YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY?	YES____NO____
DO YOU HAVE A DURABLE POWER OF ATTORNEY?	YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY?	YES____NO____

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Consent to Treat Patient

I, _____ am presenting myself for diagnosis and treatment at Dayspring Family Care, PLLC. I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of the facilities, their medical staff or designees as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment, and I understand any special procedure or treatment involving appreciable risk will be explained to me by a provider and that I may at any time refuse such treatment.

My signature below constitutes:

1. My acknowledgement, that I have **read, understand and agree** to the foregoing.
2. That I hereby give authorization and consent.

_____ _____

Signature of Patient | Witness to Signature

_____ _____

Signature of Person Signing for Patient (if patient is a minor or unable to act on his/her own behalf) | Relationship to Patient

Dayspring Family Care PLLC

Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your name, address, telephone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or at work, a message will be left on your voicemail or answering machine. **While we use secure email and texting programs, your text messaging and regular email are not encrypted and there is the risk that someone could access your information electronically. Please employ strong passwords to protect all your personal details and protected health information.**

As a part of our standard procedures, your prescription medication history (those medications purchased through your insurance company) will be downloaded into your chart. This will help us to avoid any problems when prescribing medications and this information is an important part of your overall healthcare. This information will be kept in the strictest of confidence along with all the rest of your Protected Health Information (PHI).

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

***Please note that patients may receive telephone calls or texts regarding confidential healthcare information such as lab test results and upcoming appointments. Please indicate who may receive such information on your behalf and how you would like to receive that information. If you would like to receive lab results or reminders for upcoming appointments via e-mail, please provide us with your current e-mail address.**

The following people may have access to my Protected Health Information (PHI):

//

(Name)	relationship	(Telephone #)	(Name)	relationship	(Telephone #)

//

(Name)	relationship	(Telephone #)	(Name)	relationship	(Telephone #)

*****PLEASE review the following and indicate your preferences accordingly*****

O text cell phone with appointment reminders, results, referral appointments

O Leave PHI on voicemail.

O email appointment reminders, results, referral appointment

OI choose <u>not</u> to have immunizations that I receive at Dayspring Family Care to be uploaded to the Tennessee statewide database.

I authorize you to use or disclose my health information in the manner described above.

Patient Name (printed) **Signed Name** **Date**

This authorization will expire three years after the date on which you last received services from us.

Personal Representative (printed)

Personal Representative Signature
(if patient is a minor or unable to act on his/her own behalf)

Description of Personal Representative's Authority to Act for the Patient:

Health History & Lifestyle Questionnaire

Surgical History

Surgery	Date	Place

Past Medical History *(check those that apply)*

____Diabetes Type 2	____IV Drug Use	____Diabetes Type 1
____High Blood Pressure	____Prescription Med Abuse	____Glaucoma
____High cholesterol	____Coronary Artery Disease	____Heart Attack
____Hypothyroidism	____Seizures	____Hepatitis B
____Cancer (specify) ⇨		____Hepatitis C
____Bipolar Disorder	____Stroke	____PVD
____Depression	____Allergic Rhinitis	____Suicide Attempt
____Anxiety	____Anemia	____STD
____Alcohol Abuse	____Asthma	____Other (specify)

Social History *(please circle or write your answers)*

Seat belts used routinely	Yes No	
What is your relationship status?	Sgl Mar Div Wid Sep Partner	
Are you Sexually Active?		Yes No
Do you have smoke/carbon monoxide detectors?		Yes No
Do you have any guns in your home?		Yes No
Do you routinely use sunscreen?		Yes No
What is the highest level of education completed?		
Are you currently employed?		
If so, what is your occupation?		
Diet	Regular Vegetarian Vegan Other (specify)	
Exercise Level	None Occasional Moderate Heavy	
Do you or have you ever smoked tobacco?	Yes No	
If yes, how many years?		
At what age did you start smoking?		
How much tobacco do you smoke per day?		
Chewing Tobacco	Yes No	How many times per day?
Alcohol Intake	None Occasional Moderate Heavy	
Alcohol Years of use		
Illicit Drugs	Yes No	
How much caffeine?	None Occasional Moderate Heavy	
Advance directives	Yes No	

Family History

Family Member Parent, grandparents, etc....	Illness	Age at death (if deceased)

Specialty Physician(s) that you currently see for medical care

Name	Specialty	Phone #

MEDICATIONS

Medication Allergies *(please list medication and reaction)*

Durable Medical Equipment please list all you currently use – i.e., wheelchair, walker, oxygen, Cpap, etc....)		Where do you get your DME from?

Review of Systems

Date:_____ **Name** _____

In the last **six months** have you had a problem with:

Skin

Your skin? Y / N

Endocrine

Excessive fatigue? Y / N
Night sweats? Y / N
Excessive thirst? Y / N

GI

Frequent heartburn? Y / N
Frequent indigestion? Y / N
Abdominal pain? Y / N
Abdominal cramps? Y / N
Constipation? Y / N
Bloody bowel movements? Y / N
Black/tarry bowel movements? Y / N
Nausea or vomiting? Y / N
Eating? Y / N
Swallowing? Y / N

Cardio

Dizziness? Y / N
Lightheadedness? Y / N
A thumping heart? Y / N
A racing heart? Y / N
Chest Pain? Y / N
Tightness across the chest? Y / N
Unusual bruising? Y / N

How many times have you fallen?_____

Pulmonology

Shortness of breath? Y / N
Coughing? Y / N

ENT

Seeing? Y / N
Hearing? Y / N
Smelling? Y / N
Lumps in neck? Y / N

Musculoskeletal

Arthritis? Y / N
Back Pain? Y / N
Swollen feet or ankles? Y / N
Fluid retention in legs? Y / N

Urinary

Frequent or painful urination? Y / N
Uncontrolled leaking of urine? Y / N

Constitutional

Sleeping? Y / N
Fever? Y / N
Chills? Y / N
Weight loss or gain? Y / N

Neurologic

Frequent headaches? Y / N
Numbness or tingling? Y / N

Do you have any other concerns that you would like to share with the provider?

_____

_____

_____

_____