NEW PATIENT INFORMATION

Self Pay **Chart # _____**

Medical _____ Vision _____Dental _____(extractions, fillings)

Patient Name _____Date of Birth _____ Gender: M☐ F☐
First Middle Last

Address _____
Street (PO Box) City State Zip Code

Telephone # _____ SS # _____

Cell # _____ E-mail Address _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

Race _____ Language _____ Ethnicity _____

Patient Status: ☐ Single ☐ Married ☐ Other ☐ Unemployed ☐ Employed ☐ Full Time Student ☐ Pt Time Student

Employer Name _____ Employer Phone # _____

Employer Address _____

Is Patient's Condition Related to: a) Employment (Current or Previous) _____Yes _____No

b) Auto Accident _____Yes _____ No State _____

c) Other Accident _____Yes _____ No

Dr & Hospital who have records _____

_____

_____

Previous Medical Condition(s) treated for past six (6) months or longer _____

_____

_____

_____

I give my consent to receive treatment from Servolution Health Services.

_____
Patients or Authorized Person's Signature Date

HIPAA Expiration Date _____

_____
(Office use only) Entered By

ACCIDENT/INJURY/PREGNANCY

Date of Current Illness (First Symptom) or injury (accident) or Pregnancy _____

If patient has had same or similar illness give first date _____

Dates patient unable to work in current occupation. From _____ to _____

Name of Provider or Other Source

_____

_____

_____

Hospitalization Dates for Current Services from _____ to _____

Reserved for local use

Insurance Company Name and Address

_____

_____

_____

Outside lab? Yes ____ No _____ Charges $_____

Medicare Resubmission Code _____Original Ref _____

Prior Authorization # _____

Servolution Health Services

MEDICAL HISTORY

Patient Name_____ Birthdate_____

Thank you for answering the following questions:

Are you under a physician's care now? O Yes O No If yes, please explain:_____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No If yes, please explain:_____
Are you on a special diet? O Yes O No If yes, please explain:_____
Do you use tobacco? O Yes O No If yes, please explain:_____
Do you use controlled substance? O Yes O No If yes, please explain:_____

Women: Are you

Pregnant/Trying to get pregnant? ____Yes ____No Taking oral contraceptives? ____Yes ____No Nursing? ____Yes ____No

Are you allergic to any of the following?

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Latex _____ Local Anesthetics

_____ Other If yes, please explain: _____

_____

_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes					
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No				
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No				
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No				
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No				
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No				
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No				
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No				
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No				
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No				
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No				
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No				
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No				
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No				
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No				
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No				
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No				
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No				
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No							

Have you ever had any serious illness not listed above? _____Yes _____ No If yes, please explain:

_____

_____

_____

_____

Have you ever been hospitalized or had a major operation? If yes, explain: _____

_____

_____

_____

Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the medical office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____DATE _____

SERVOLUTION HEALTH SERVICES
181 POWELL VALLEY SCHOOL LANE
SPEEDWELL, TENNESSEE 37870
(423)419-5070 (423)419-5071 FAX (423)869-0081

CONSENT FOR PATIENT CONTACT

Date _____

Patient's Full Name _____

Date of Birth: _____/_____/_____ **Social Security Number** _____

From time to time, it may be necessary for Servolution Health Services to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- **Make an appointment**
- **Cancel an appointment**
- **Inform you that your prescriptions have been called in or need to be picked up**
- **Discuss your medical care and treatment**
- **Verify address and phone numbers, etc.**

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (Please check the box(s) that apply)

☐ Leaving a recorded voicemail on my: ☐ home phone or cell phone ☐ work phone ☐ e-mail
e-mail address _____ cell phone carrier _____
☐ Leaving a message with anyone who answers my telephone at home
☐ (Specify)

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

☐ No One

I give my consent for any representative of Servolution Health Services to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

Amendment: I give my consent for electronic access to records via secured electronic medical (EMR) patient portal using above e-mail address or cell.
Alternate contact who may access my records via secured EMR patient portal.

Name _____ **E-Mail** _____

_____ _____
Signature **Date**

SERVOLUTION HEALTH SERVICES
181 POWELL VALLEY SCHOOL LANE
SPEEDWELL, TENNESSEE 37870
(423)419-5070, (423)419-5071, FAX (423)869-0081

RELEASE OF INFORMATION/AUTHORIZATION

Patient's Full Name _____Expiration Date _____

Date of Birth: _____/_____/_____Social Security Number _____

Servolution Health Services (SHS) knows that health information is personal, and we are committed to protecting the privacy of your information. As a patient of SHS, the care and treatment you receive is recorded in a healthcare record. In order to best serve your medical needs, we sometimes must share your medical record, in whole or in part, with other healthcare providers involved in your treatment or with other entities during the normal business operations. We will not use or disclose your health information for any other purpose without your permission.

I _____, give my consent and authorize Servolution Health Services
PRINT NAME HERE

to release information from my records to other healthcare providers for purposes of continuity of care.

In addition, I give SHS my consent and authorization to obtain my medical, dental, and/or behavioral/mental health records from other providers for purposes of continuity of care.

Also, I give my consent for electronic access to records via secured electronic medical record (EMR) patient portal.

This authorization may be revoked by me at any time by written notice to SHS, expect to the extent that action has already been taken.

I have the right to refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment unless allowed by law. However, refusal to sign may limit our ability to further your treatment beyond what can be done in house.

This **consent expires one year** from its date of acceptance.

Signature of Patient: _____ Date: _____

Signature of Witness: _____

Signature of Parent, Guardian, or Legal Representative: _____ Date: _____

ALL AUTHORIZATIONS MUST BE MAILED TO ADDRESS AT TOP OF THE FORM.
WE CAN ACCEPT FAXED REQUESTS FROM HEALTHCARE PROVIDERS ONLY.