

NEW PATIENT INFORMATION

Chart # _____

Uninsured

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 _____

Number lives in House _____ Monthly Household Income \$ _____ Annual Household Income \$ _____

Source/Proof of Income (Any/All) Wages, salary, tips, unemployment, social security, disability, food stamps, child support, alimony, pension, annuity, veteran's benefits, military family allotments, tax return, and any support provided by relatives and friends.)

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

PATIENT _____ **CHART #** _____

TOTAL NUMBER IN HOUSEHOLD: _____

Patient	Self	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount

TYPES OF INCOME (Abbreviations) (CIRCLE ANY/ALL THAT APPLIES)

Social Security	SS	Pension/Retirement	PEN/RET
Social Security Disability	SSI	Bank Statement	BS
Child Support	CS	Tax Return	TR
Family First	FF	Pay Check Stub	PS
Unemployment	UEMP	Food Stamp Approval Letter	FS
Employer Letter	EL	Support Letter	SL
VA Benefits	VA		
Other (O) _____			

To the best of my knowledge, the information is complete, accurate, free from any misstatements and is not misleading in any respect.

Signature

Date

Signature of Servolution Employee

Date

Information Expires one (1) year from 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 record (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, except 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.**

Servolution Health Services, Inc.

NOTICE TO PATIENTS

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 23 U.S.C. sections 1346(b), 2401(b), 2671-80), provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board members, officers, employees, or independent contractors who have provided a required or authorized service under Title XIX of the Social Security Act (i.e. Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. section 233 (a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1977 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

(Patient Signature)

(Patient Name, Printed Legibly)

Date