West Tennessee HEALTHCARE™ | Henry County Hospital

Patient Information

Please Print

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN: _____ Gender: Male/Female (circle one)

Email address: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ Home or Cell (circle)

Employer: _____ Employer Phone #: _____

Emergency Contact: _____ Emergency contact phone: _____

Parent or Legal Guardian: _____ DOB: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Preferred Communications: Email _____ Telephone _____ Text _____

Primary Care Provider (name and phone number): _____

Preferred Pharmacy: _____ Mail order (if applicable): _____

Marital Status (circle): Declined Married Single Widowed Divorced

Race (circle): Declined Native Hawaiian/Pacific Islander Caucasian/White Asian Native American
American Indian/Alaskan Native African American/Black Other

Sexual Orientation (circle): Declined Heterosexual Lesbian or Gay Bisexual Pansexual
Something else: please specify: _____

Ethnicity (circle): Not Hispanic/Latino Hispanic/Latino Other: _____

Person Responsible for Bill:

Primary Insurance: _____ Subscriber ID: _____ Group ID: _____

Name of Subscriber/Policy Holder: _____ DOB: _____

Secondary Ins: _____ Subscriber ID: _____ Group ID: _____

Name of Subscriber (if different): _____ DOB: _____

Consent to Contact regarding your care:

Contact Name & Phone Number: _____

How is this person related to you? _____

Contact Name & Phone Number: _____

How is this person related to you? _____

I give permission to HCMC Clinics to disclose my Protected Health Information to the person I have listed above. I understand that I can revoke this authorization any time, in writing.

Signature: _____ Date: _____

West Tennessee Medical Group

Consent for Treatment and Financial Responsibility

Patient Authorization for treatment and financial responsibility at a West Tennessee Medical Group ("WTMG") facility:

1. I consent to West Tennessee Healthcare ("WTHC"), West Tennessee Medical Group ("WTMG"), and WTHC and WTMG providers (collectively "Provider") to provide the treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring provider, my primary care provider, and my insurance company, if applicable.
3. I allow fax or another appropriate electronic method to transmit my medical records.
4. I understand that payment is due for charges at the time of service unless other definite financial arrangements have been made before treatment.
5. If the charges are not paid in full when due, I agree to be responsible for and to pay in addition to the charges for services and treatment received. If I fail to pay those charges, I agree that I am will also pay all costs associated with such collection activity, including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs.
6. I consent to Provider or its agents communicating with me by phone or email. By giving this consent, I understand that Provider may call, text, or email me by any method for any account-related purpose and to request my participation in patient satisfaction surveys. I understand that standard text and data rates may apply to the calls or texts.
7. I have been made aware and understand the medical practices and offices may use an electronic prescription system that allows prescriptions and related information to be electronically sent between my providers and my pharmacy. Further, I have been informed and understand that my providers using the electronic prescribing system will see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
8. I have been made aware of and understand that Provider may provide certain treatments via telehealth. I further understand and acknowledge that I may refuse telehealth services and instead request an in-person visit. I understand that if I refuse to participate in telehealth services, such refusal will not affect my right to future care or treatment. I acknowledge that if I participate in telehealth services I am consenting to the use of telehealth.
9. I further authorize and request that insurance payments be made directly to Provider.
10. I agree to take full financial responsibility for services rendered by Provider.
11. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.

_____ _____ _____ _____

Patient (or Guardian) Signature Date Witness Date

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of The Clinic's Joint Notice of Privacy Practices.

_____ _____ _____

Name (Print) Signature (Relation, if other than patient) Date

☐ Patient unable to sign/ No family available
☐ Patient refused to sign
☐ Other:

☐ Employee
Signature:_____
The Clinic's Use Only (Do not write below this line)

Date acknowledgment mailed: _____
Date acknowledgment received: _____

Advanced Directives:

Do you have a living will or durable power of attorney? ☐ No ☐ Yes

If you do have a durable power of attorney, please identify:

_____

Would you like us to give you a packet of information regarding advance directives:
☐ No ☐ Yes (Packet distributed)

_____ _____ _____ _____

Patient Signature Date Witness Date

Discrimination is Against the Law

Title VI of the Civil Rights Act of 1964 requires that federally assisted programs be free of discrimination. The Tennessee Department of Health also requires that its services be offered to all eligible persons. Jackson-Madison County General Hospital District ("the District") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). The District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The District:

- ✓ Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- ✓ Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Interpreter Services at (731)541-4676 or page them at (731)935-5690. They are available from 8:00 a.m. to 4:30 p.m., Monday – Friday. After hours and weekends, please call the operator at (731)541-5000.

If you believe that the District has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by

mail, fax, or email with the Civil Rights Coordinator: Amy Garner, VP/Chief Compliance Officer

Jackson-Madison County General Hospital District

620 Skyline Drive, Jackson, TN 38301

Telephone: (731)541-2970 Fax: (731)541-9404 Email: Amy.Garner@WTH.org

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services

200 Independence Ave., SW Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at WTH's website: wth.org.

Patient/representative signature: _____

Date:_____

Patient Name: _____ **Date:**_____

Who is your regular doctor? _____

Please list all medications you are taking. Pharmacy: _____

Medication	Strength	How often do you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

What medications are you allergic to and what are the symptoms of the allergy?

Medication	Symptom to the allergy

Have you had any operations? When? (approximately)

- ☐ Stomach Surgery(including surgery for ulcers, reflux, etc.)_____
- ☐ Intestine or Colon surgery_____
- ☐ Thyroid/Parathyroid Surgery_____
- ☐ Rectal or Hemorrhoid surgery_____
- ☐ Heart Surgery_____
- ☐ Heart Catheterizations(cath's including stents or angioplasty)_____
- ☐ Weight loss or Bariatric Surgery_____
- ☐ Endoscopy (including Colon/large intestine, Esophagus, Stomach, or EGD)_____
- ☐ Operations on blood vessels (including stents or regular surgery)_____
- ☐ Breast Surgery (including biopsy, mastectomy, augmentation, or reduction)_____
- ☐ Female Surgery (including hysterectomy, scopes, or c-sections)_____
- ☐ Kidney or Bladder surgery_____
- ☐ Spine Surgery (including disc or fusions_____
- ☐ Orthopaedic Surgery (including scopes, joints replacement, etc) _____
- ☐ Chest or Lung Surgery._____ Tonsil or Sinus Surgery_____
- ☐ Hernia Surgery _____ Eye Surgery_____
- ☐ Appendix_____ Gallbladder_____
- ☐ Brain Surgery_____ Skin Operations_____
- ☐ Other: _____

Patient Name: _____ **Date:** _____

Family History (diseases that run in your family)

- ❑ Breast cancer
- ❑ High blood pressure
- ❑ Colon cancer
- ❑ High cholesterol
- ❑ Thyroid cancer
- ❑ Psychiatric illness
- ❑ Peripheral Vascular Disease
- ❑ Joint problems
- ❑ Kidney Disease
- ❑ Headaches/Migraines
- ❑ Coronary Artery Disease
- ❑ Varicose Veins
- ❑ Thyroid Disease
- ❑ Ovarian cancer
- ❑ Heart attack
- ❑ Diabetes
- ❑ Stroke
- ❑ Obesity
- ❑ Other _____

Smoking

	(Circle one)		
Do you smoke currently?	Yes	No	# of packs? _____
If not, have you ever smoked?	Yes	No	How many years? _____
Have you quit smoking?	Yes	No	
Do you use any other form of tobacco?	Yes	No	

Alcohol and other drugs

Do you drink alcohol?	Yes	No	How Often? _____
Have you ever had a drinking problem?	Yes	No	
Have you ever used illegal/street drugs?	Yes	No	
Have you ever had an addiction?	Yes	No	

Other

Marital Status (circle one) Married Single Divorced Widowed

Highest grade completed _____ Occupation _____

Do you have any of the following ongoing problems

- ❑ Unintentional or unexplained weight loss
- ❑ Loss of appetite
- ❑ Severe tiredness or fatigue
- ❑ Lack of stamina, strenth or endurance
- ❑ Blurred vision
- ❑ Double vision
- ❑ Ringing in ears
- ❑ Drainage from ears
- ❑ Nosebleeds
- ❑ Sinus trouble
- ❑ Hoarseness
- ❑ Painful or difficult swallowing
- ❑ Chronic Cough
- ❑ Coughing up blood or bloody mucous
- ❑ Jaundice or yellow jaundice
- ❑ Indigestion
- ❑ Stomach fluid washing into mouth
- ❑ Chronic cough after going to bed
- ❑ Swelling
- ❑ Depression/anxiety
- ❑ Vomiting blood
- ❑ Change in bowel habits
- ❑ Frequent constipation or diarrhea
- ❑ Frequent nausea or vomiting
- ❑ Abdominal distention or swelling
- ❑ Loss of control of urine
- ❑ Blood in urine
- ❑ Burning with urination
- ❑ Swollen glands
- ❑ Abnormal bleeding
- ❑ Back pain
- ❑ Headache
- ❑ Slurred speech
- ❑ Loss of balance
- ❑ Serious tremor
- ❑ Memory loss
- ❑ Prolonged exposure to sun
- ❑ Blistering sunburn
- ❑ Shortness of Breath
- ❑ Muscle pain/ Joint pain

Patient Name: _____ **Date:**_____

Do you have any of the following?

- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Heart attack How many? _____
  When was last one? _____
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ COPD (Chronic Obstructive Pulmonary dx)
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Tuberculosis (TB)
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Ulcers
- ☐ Hiatal Hernia
- ☐ Stricture
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Colon Polyps
- ☐ Reflux
- ☐ Diabetes (circle one)
  Diet Insulin Oral meds
- ☐ Kidney Stones
- ☐ Renal Failure
- ☐ Prostate Enlargement
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Gout
- ☐ Blood clots in leg veins
- ☐ Blockage in arteries? Where _____
- ☐ Aneurysms
- ☐ Stroke
- ☐ Migraines
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Arthritis
- ☐ Ulcerations/Sores on feet or legs
- ☐ Heart Disease
- ☐ Varicose Veins
- ☐ Gangrene
- ☐ Palpitations
- ☐ Peripheral Vascular Disease

Any other medical problems?

_____
_____
_____
_____
_____

<u>Woman Only</u>

Number of pregnancies _____
Number Miscarriages _____
Age beginning periods _____
Age of menopause _____
Did you breast feed? Yes No
Do you take estrogens? Yes No
Do you take birth control pills? Yes No

Do you have any of the follow problems?

- ☐ Breast pain or soreness
- ☐ Endometriosis
- ☐ Discharge from nipple
- ☐ Abnormal menstrual periods
- ☐ Abnormal vaginal bleeding
- ☐ Vaginal Discharge

Have you had or do you have any type(s) of cancer?

- ☐ Skin
- ☐ Melanoma
- ☐ Breast
- ☐ Lung
- ☐ Colon
- ☐ Stomach
- ☐ Cervical
- ☐ Uterine
- ☐ Ovary
- ☐ Prostate
- ☐ Leukemia
- ☐ Lymphoma

Other _____
_____
_____
_____