WEST
Clinic

Stanley L. Smith, Jr., M.D.

Patient Information Form

Welcome to the West Clinic

We want to provide excellent service.
The following information will allow us to accurately handle your billing and insurance.

Age _____

Date _____ **Referring Physician** (First) (Last) _____ **Primary Care Physician** (First) (Last) _____
(Referring and Primary Care physician may receive your medical records)

Please present Insurance Card and Photo ID

Patient Name _____ Date of Birth_____ /_____ /_____ SSN _____

❑ Male ❑ Female Marital Status: ❑ Married ❑ Widowed ❑ Single ❑ Divorced

Mailing Address _____ City _____ State_____ Zip_____

County _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone_____

Contact Preference ❑ Home ❑ Work ❑ Cell

Spouse/(Next of Kin) _____ Relationship _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Employer _____ Work Phone_____

Pharmacy _____ Phone _____

Pharmacy Cross Streets _____

Primary Insurance _____ Policy Holder _____ Policy Holder DOB _____

Secondary Insurance _____ Policy Holder _____ Policy Holder DOB _____

Information required by Federal Government

Race ❑ Caucasian/White ❑ African American/Black ❑ American Indian ❑ Asian ❑ Other

Ethnic Background ❑ Hispanic ❑ Non Hispanic **Preferred Language** _____

Internal Office Use Only

Verified by_____ MRN_____

WEST Clinic

MEDICAL HISTORY FORM

PATIENT NAME: _____ **D.O.B.** _____

SURGICAL HISTORY:

Please list any previous surgeries you have had and when you had them:

SURGERY	WHEN?
_____	_____
_____	_____
_____	_____

OFFICE USE ONLY

MEDICAL HISTORY:

Please list any medical problems you have and their duration:

PROBLEM	HOW LONG?
_____	_____
_____	_____
_____	_____

Have you ever been diagnosed with sleep apnea? ❑ YES ❑ NO

Are you allergic to latex? ❑ YES ❑ NO

Please list any Drug Allergies you have:_____

_____

CHECK SYMPTOMS YOU MAY HAVE:

- ❑ weight loss
- ❑ fever
- ❑ difficulty with eyes, ears, nose or throat
- ❑ chest pain
- ❑ shortness of breath
- ❑ cough
- ❑ nausea/vomiting
- ❑ sweats
- ❑ constipation/diarrhea
- ❑ blood in stool/black stool
- ❑ abnormal menstrual periods
- ❑ blood in urine
- ❑ difficulty with urination
- ❑ bone / joint pain
- ❑ vaginal problems
- ❑ skin rash / lumps
- ❑ fainting
- ❑ numbness / weakness
- ❑ sexual problems
- ❑ dizziness / blackout spells
- ❑ swollen glands

SOCIAL HISTORY:

1. Occupation: _____
2. Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed
3. Lives with _____ Transportation _____
4. Do you smoke? ❑ YES ❑ NO
   IF YES, estimate how many packs a day: _____
   IF YES, how many years have you smoked? _____
5. Are you a former smoker? ❑ YES ❑ NO
   IF YES, how many years did you smoke? _____
   IF YES, when did you quit smoking? _____
   IF YES, estimate how many packs per day? _____
6. Do you drink alcoholic beverages? ❑ YES ❑ NO
   IF YES, how many drinks do you have per week? _____
7. Do you have a history of recreational drug use? ❑ YES ❑ NO

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MEDICATION LOG

Patient Name: _____

It is important to have a complete record of your current medications. This list will include over the counter medications, the dosage, how it is taken (scheduled), and the doctor who prescribed this for you.

Medication	Dose	Schedule (How taken)	Doctor who prescribed

WEST
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PATIENT REPRESENTATIVE IDENTIFICATION FORM

PATIENT NAME _____ **DOB** _____

(Office use only) **CHART #** _____

By law, the HIPAA Privacy Rule Prohibits The West Clinic from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This Rule became effective April 14, 2003.

1) Please list the names of all persons that you wish to have access to your Protected Health Information (PHI) (i.e. those making appointments or checking on test results for you):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

2) Please list the name of the person(s) with whom we can discuss your bill:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

3) If applicable, please list the name of your Legal Representative:

Name: _____ Relationship to Patient: _____

Check one: By what authority is this person your Legal Representative?

❑ Next of Kin ❑ Guardian ❑ General Power of Attorney ❑ Health Care Power of Attorney

PLEASE NOTE: In order for us to disclose your Private Health Information, the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

- Patient's social security number
- Patient's date of birth; or
- Patient's zip code

Patient Signature: _____ Date: _____

Financial Policy

Thank you for choosing The West Clinic as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we would like to work with you to ensure insurance benefits and financial assistance are maximized.

If you have health insurance:

West Clinic accepts assignment of insurance benefits for Medicare, Medicaid, TennCare, MS CAN, Workers' Compensation and many Commercial health insurance plans. Your insurance policy is a contract between you and your insurance company. Please inform us of all health insurance carriers and if you have more than one, indicate which is primary and secondary. If your insurance coverage changes, please inform our office as soon as possible so we can file your claims properly.

West Clinic will file a claim with your health insurance company for services you receive. The patient balance as determined by your policy is your responsibility and will be requested at the time of service. **If your insurance company has not paid within 120 days of the date of service, the balance will be transferred to you.**

As the patient, you are responsible for knowing your policy benefits, especially which outside lab to use, where pathology specimens should be sent and whether you can have radiology services in our office.

If you do not have health insurance:

If you do not have insurance coverage payment for services will be requested at the time services are rendered. Our policy is to reduce the usual and customary rates charged to uninsured patients to approximate the payment rates allowed by private insurance companies in the market. Please contact our Patient Representatives at (901) 683.0055 prior to your visit to discuss payment options.

I acknowledge receipt of The West Clinic Financial Policy and authorize The West Clinic, P.C. to release to my health insurance company or organizations that provide financial assistance, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The West Clinic, P.C.

Patient or Patient's Representative Signature: _____ Date: _____

Patient Privacy Notice

I acknowledge that West Clinic's Privacy Notice has been made available to me.

Patient or Patient Representative Signature: _____ Date: _____

Advanced Directive for Medical Care (Living Will)

Do you have a Living Will? Yes No

Did you bring a copy with you? Yes No

I acknowledge that if I have a Living Will or any form of Advanced Directives I should inform the clinic and present a copy, even if one is created after my initiation of care.

Patient or Patient's Representative Signature: _____ Date: _____

The University of Tennessee
WEST Cancer Center
Methodist Healthcare Family

WEST CANCER CENTER

Authorization For West Cancer Center to obtain Your medical records from other care providers

"Patient, please complete and sign this form so we can request your records from other providers"

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I,_____, Date of Birth_____do hereby authorize West Cancer Center to obtain, use, disclose or receive my individually identifiable health information as described below :

FROM: Any of my healthcare providers or institutions containing records pertinent to my care

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE CHOOSE AND INITIAL A OR B

X **A** **Complete medical record** which may contain treatment notes regarding radiology, pathology ***(including HIV test results and genetic testing information),*** immunization, procedure(s), ***alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2,*** and other common medical record documentation by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

_____ **B** For information collected/services described below and provided **during the time period of :** _____

_____

Description of records to be released: _____

_____

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Release my records to

ATTN: West Cancer Center

For the purpose(s) of: Treatment, Payments or Operations

I understand that I may withdraw my authorization in writing to West Cancer Center at any time, except to the extent that action has been taken in reliance on this statement. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to West Cancer Center. If this authorization has not been revoked, and if I have not indicated an expiration date, this authorization will expire one year from the date of execution.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM**
- **WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST**
- **I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY**

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative _____

Description of the Representative's authority to act in behalf of the patient _____

Relationship to the patient: _____

*For information about how your medical information may be used or disclosed, please see the Patient Notice.