NEW LIFE MEDICAL CENTER
9160 Highway 64, Suite 105
Lakeland, TN 38002
O: 901-213-0100/F: 901-213-0101

PATIENT REGISTRATION FORM

Date_____ Chart #_____

PATIENT INFORMATION

How did you hear about our clinic? _____ Referral Name_____

Last Name _____ First Name_____ M Initial____

SSN#_____ Date of Birth_____ ☐ ☐ M / F Age_____ HT_____ WT_____

Address_____ City _____ST_____ZIP_____

Cell Phone_____ Other phone_____ E-mail Address_____

Employer_____ Work Phone_____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Employment status (circle) ◉Full-time ○Part-time ○Retired ○Active Military ○None

Name of Pharmacy: _____ Phone Number: _____

How can we contact you for appointment reminders? ☐Cell ☐Text ☐Email ☐Other

EMERGENCY CONTACT

Name_____ Phone# _____ Relationship to Patient_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____**POLICY HOLDER**_____

POLICY HOLDER INFORMATION (IF DIFFERENT THAN YOURSELF)

Name_____ Date of Birth_____

Patient relationship to Policy Holder_____

SECONDARY INSURANCE_____**POLICY HOLDER**_____

Name_____ Date of Birth_____ Patient relationship to Policy Holder_____

AUTHORIZATIONS

I hereby authorize any payment to **NEW LIFE MEDICAL CENTER** for medical services under the terms of my insurance benefits. I authorize release of any medical information to Insurance carriers and/or referring providers. I consent to examination and treatment by **NEW LIFE MEDICAL CENTER**. This consent will remain in effect from this date forward unless written revocation if such is duly presented to the office of **NEW LIFE MEDICAL CENTER**, by myself or a legally authorized representative. I understand I have the right to question and/or refuse any proposed treatment, absent emergency or extraordinary circumstances.
In consideration of receiving services from **New Life Medical Center**, I Agree:

- I am responsible for all expenses for receiving treatment
- Payment of charges are due at the time of service unless prior arrangements have been made.
- If **New Life Medical Center** files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles
- **New Life Medical Center** has explained to me an **ESTIMATE** of what my responsibilities may be after my benefits have been applied to each visit.

Print Name: _____

Signature: _____ Date: _____

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BE ALL YOU WERE BORN TO BE

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	

Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICAL HISTORY

Date of last physical exam: _____

CHECK ALL THAT APPLY

☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ DIABETES
☐ HEART FAILURE	☐ ASTHMA	☐ CANCER
☐ HIGH BLOOD PRESSURE	☐ BRONCHITIS	☐ DEPRESSION
☐ FAINTING	☐ SLEEP APNEA	☐ ANXIETY
☐ BLOOD CLOTS	☐ SEASONAL ALLERGIES	☐ HIV
☐ SWELLING IN FEET/LEGS	☐ PNEUMONIA	☐ HEPATITIS
☐ HIGH CHOLESTEROL		☐ OTHER _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH
Father			**Sibling**	☐ M☐ F
Mother			**Sibling**	☐ M☐ F

Surgeries/Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (Use back of this sheet if needed)

Drug/Strength/Frequency	Drug/Strength/Frequency	Drug/Strength/Frequency

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS

Exercise	Do you exercise ☐ Yes, How often? _____ ☐ No			
Diet	Are you dieting? ☐Yes ☐No			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
Alcohol	Do you drink alcohol? ☐Yes, How often? _____ ☐No			
Tobacco	☐ Cigarettes – How many per day? _____ ☐ Chewing Tobacco – How much per day? _____			
Drug use	☐Yes ☐No			

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

NEW LIFE MEDICAL CENTER Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of out Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice.

You have the right to revoke this consent, in writing, except where you have already made disclosures in reliance on your prior consent.

I have read the NEW LIFE MEDICAL CENTER Notice of Privacy Practices

_____ _____

Patient Signature Date Signed

_____ _____

Print Name Patient Date of Birth

I hereby authorize this office to release my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment and health, to the persons I have listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any person who is not listed above will not be able to obtain my protected health information (PHI). It is not necessary to list other treating physicians or insurance companies. When notifying me of lab or test results, matters relating to prescriptions, appointments, and accounts status the practice may call:

Phone Number: _____ ☐ Home ☐ Cell ☐ Other

Patient Signature: _____ Date: _____