PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Atoka Medical Clinic. This form is used to collect information about new patients and used for internal purposes only. The information you supply will be confidential and will be treated accordingly.

PATIENT DETAILS

First Name:_____ Last Name:_____
Date of Birth:_____Gender:_____
Street Address:_____City:_____
State:_____Zip Code:_____Home Phone:_____
Mobile Number:_____SSN Number: _____
E-Mail:_____Race/Ethnicity:_____
Language:_____Marital Status:_____

EMERGENCY CONTACT

Contact Name:_____Relationship:_____
Phone:_____E-Mail:_____

TREATING PHYSICIANS

Primary Care Physician:_____Phone:_____
Physician:_____Specialty:_____
Physician:_____Specialty:_____
Physician:_____Specialty:_____

PATIENT CONFIDENTIALITY:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

TREATMENT AUTHORIZATION

I hereby authorize Katrina Korzoloski, FNP-C and her associates to undertake medical treatment and diagnostic testing as deemed medically necessary.

Printed Patient Name:_____

Patient Signature:_____Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and understood Atoka Medical Clinic Notice of Privacy Practices containing a description of the uses and disclosures of my protected health information. I further understand that Atoka Medical Clinic may update its Notice of Privacy Practices at any time and that I may receive an updated copy of Atoka Medical Clinic's Notice of Privacy Practices by submitting a request in writing for a current copy of Atoka Medical Clinic's Notice of Privacy Practices.

Printed Patient Name: _____

Patient Signature:_____Date:_____

only sign if applicable:
Printed Patient Representative:_____

Representative Signature:_____Date:_____

**********ATOKA MEDICAL CLINIC OFFICIAL USE ONLY**********

Complete below if unable to obtain signature of patient or patient's personal representative. Atoka Medical Clinic made a good faith effort to obtain the patient's written acknowledgement of the Notice of Privacy Practices but were unable to do so for the reasons documented below:

Patient or Patient's representative UNABLE to sign.

Patient or Patient's representative REFUSED to sign.

Other:_____

Printed Employee Name:_____

Employee Signature:_____Date:_____

Release of Medical Information

I,_____, hereby give authorization to release confidential information regarding my medical status including the following information:

Patient Name:_____Date of Birth:_____
SSN Number:_____Phone:_____

From:_____
Phone:_____Fax:_____
(Name of provider release information)

Please Send Records to:
Atoka Medical Clinic P:901-296-1156
60 Commercial Dr F: 901-296-0430
Atoka,TN 38004

For the purpose of records being released/disclosed to our facility for review:
_____
Information to be released/disclosed:
_____

By signing this form, I authorize you to release confidential health information about me. By releasing a copy of my medical record, or a summary of narrative of my protected health information to the physician/facility above. I understand this authorization is effective immediately and shall be valid for one year from today's date.

Patient Signature:_____Date:_____

AUTHORIZATION TO FILE INSURANCE

I authorize Atoka Medical Clinic to release pertinent information related to or concerning my medical condition to any insurance company, attorney, or adjuster in order to process a claim for reimbursement of charges incurred for services rendered by the clinic or any member of the staff acting on the clinic's behalf.

ASSIGNMENT OF BENEFITS

I agree that any payment from my insurance company or lawyer for services I received can be sent directly to Atoka Medical Clinic. If my insurance company doesn't pay, I give Atoka Medical Clinic the right to take legal action on my behalf or in their name to collect payment. The clinic can also settle or resolve the claim as they see fit.

If I have no insurance, I will pay Atoka Medical Clinic in full for services rendered. I agree to pay the full amount billed within 30 days after I am billed.

LATE PAYMENTS

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services and/or supplies rendered. I also agree that if my account is sent to collections, I will be responsible for the balance on my account for any professional services and/or supplies rendered. I also agree that if my account is sent to collections, I will be responsible for my balance in full plus the collection agency fees and/or attorney fees at a rate of 33% of the balance I owe.

NO-SHOW FEE

We value your time and request that you respect ours. I understand and agree that appointments missed without notice will be charged a $25 No-Show Fee. This fee is due before any future appointments can be scheduled.

DISABILITY PAPERWORK/FMLA

Disability forms are lengthy and take time and attention away from our medical staff. The fee for completing $40 per form. This fee must be paid before the forms can be completed and returned.

RETURNED CHECK FEE

If a check is returned by the bank due to insufficient funds or any other reason a $30 fee will be added to your account. You will be responsible for paying the original amount plus the returned check fee.

CARD PROCESSING FEE

A 4% processing fee will be added to all payments made with a credit card. This fee goes directly to cover the costs charged by the card processing companies.

Printed Patient Name:_____

Patient signature:_____Date:_____

Staff Initials:_____

IMPORTANT!!!!!

PLEASE DO NOT WEAR PERFUME, COLOGNE,FRAGRANT BODY LOTION, OR ANY FRAGRANCE, ESPECIALLY AXE PRODUCTS TO YOUR APPOINTMENTS.

A large number of our patients, as well as our staff, have breathing issues such as COPD and/or ASTHMA.

These fragrances can cause allergic reactions and affect a person's breathing.

Thank you for your cooperation!!

Patient Initals:_____Date:_____

ALLERGIES

Allergy:_____Reaction:_____Allergy:_____Reaction:_____
Allergy:_____Reaction:_____Allergy:_____Reaction:_____

MEDICATION

Pharmacy:_____
Medication:_____Dosage:_____Medication:_____Dosage:_____
Medication:_____Dosage:_____Medication:_____Dosage:_____
Medication:_____Dosage:_____Medication:_____Dosage:_____

FAMILY HEALTH HISTORY

Relative	Condition	Living?	If deceased, at what age?
Mother			
Father			
Sibling			
Other:			
Other:			

SURGICAL HISTORY

Description	**Doctor**	**Location**	**Year**

MEDICAL HISTORY CONTINUED

Anemia	Y	N	Fibromyalgia	Y	N
Arthritis	Y	N	GERD	Y	N
Asthma	Y	N	Heart Disease	Y	N
Atrial Fibrillation	Y	N	Hyperinsulinemia	Y	N
Bleeding Problems	Y	N	Hyperlipidemia	Y	N
Benign Prostatic Hyperplasia	Y	N	Male hypogonadism	Y	N
Coronary Artery Disease	Y	N	Hypothyroidism	Y	N
Cancer	Y	N	Infection Problems	Y	N
Cardiac Arrest	Y	N	Insomnia	Y	N
Celiac Disease	Y	N	Irritable Bowel Syndrome	Y	N
Chest Pain	Y	N	Kidney Problems	Y	N
Congestive Heart Failure	Y	N	Menopause	Y	N
Chronic Fatigue Syndrome	Y	N	Migraines/Headaches	Y	N
Depression	Y	N	Neuropathy	Y	N
Diabetes	Y	N	Onychomycosis	Y	N
Drug/Alcohol Abuse	Y	N	Pulmonary Embolism	Y	N
Erectile Dysfunction	Y	N	Seizure Disorder	Y	N
Sinus Conditions	Y	N	Shortness of Breath	Y	N
Syndrome X	Y	N	Stroke	Y	N
Wheat Allergy	Y	N	Tremors	Y	N
Hypertension	Y	N			

SOCIAL HISTORY

Do you currently consume alcohol? YES NO

How many drinks per week?_____

Do you currently smoke? YES NO

What do you smoke?_____

How many cigarettes do you smoke per day?_____

Do you currently use any other drugs? YES NO

What other drugs do you take?_____

How often? _____

Do you drink caffeine? YES NO

How many cups per day?_____

Complete the following if applicable:

When was your last menstrual cycle?_____

HEALTH CONCERNS

What's your primary health concern?_____

Approximately when did this issue begin?_____