Comprehensive Wellness Center

Patient's Full Name ______________________________ DOB ____________

Social Security # ______-______-______

Address ______________________________________

City ______________ State __________ ZIP ___________

Home Phone ____________ Cell Phone ______________ Email ______________

Employer ____________________ Occupation ________________________

Work Phone Number __________________

Emergency Contacts:

Name _______________________________ Phone Number _______________

Name _______________________________ Phone Number _______________

Primary Insurance ________________________

ID# _____________ Group# ____________ Network __________

Policyholder's Name ____________________________ DOB ____________

Policyholder's SS# ____________________

Relationship to patient __________________

Secondary Insurance ______________________

ID# _____________ Group# ____________ Network __________

Policyholder's name ____________________________ DOB ____________

Policyholder's SS# ____________________

Relationship to patient __________________

May we leave messages on your cell phone or home phone voicemail regarding results and/or appointment information? ____

Please list anyone we may release your medical information to.

Name _______________________________

Name _______________________________

Name _______________________________

Patient's (Guardian) Signature ________________________ Date ____________

CWC-9-417

COMPREHENSIVE WELLNESS CENTER PATIENT HISTORY

Patient Name ______________________________ DOB ______________

Current Medications: ______________________________

____

____

____

ALLERGIES: ______________________________

____

Past Medical History:

____

____

Past Surgical History: ______________________________

____

____

Are you experiencing any of the following? (please circle)

Wt. loss Wt. gain Headaches Anxiety Depression Mood Swings

Fatigue Difficulty Sleeping Loud snoring Vision Disturbance Hearing Disturbance

Dizziness Allergies Nosebleeds Mouth sores Sore throat Tooth pain

Chest pain Chest heaviness Chest tightness Palpitations

Cough Wheezing Shortness of breath

Abdominal pain Heartburn Food getting "stuck" when swallowing Painful Swallowing

Change in bowel habits Chronic diarrhea Chronic constipation Blood in stools

Leg swelling Muscle weakness Joint pain/stiffness/swelling Numbness

Blood in urine Painful urination Urinary incontinence Kidney Stones

Difficulty urinating Weak urine stream Erection difficulty Low Sex Drive Testicular Pain/Swelling

Breast mass Nipple discharge Vaginal Bleeding Irregular Menses Heavy/Painful Menses

Skin rash Skin lesion New mole Changing mole Bruising Seizures

Other ______________________________

____

____

____

Do you feel rested when you wake up? ❑ Yes ❑ No

Please indicate the last year in which you have had any of the following immunizations:

_______Tetanus _______Hepatitis B series _______Pneumovax _______Prevnar 13

_______Flu shot _______Shingles _______Measles, Mumps, Rubella

Please indicate the last year in which you have had any of the following:

_______Physical exam _______Eye exam _______Dental exam _______Chest X-ray _______EKG

_______Prostate Exam _______Testicular Exam _______Mammogram _______Pap Smear

_______Colonoscopy _______Stress Test

Do you use tobacco products? (please circle)

No Cigarettes Smokeless Tobacco Pipe Cigars

How much do you or did you smoke? ________________ Pack(s) per day for ____________________ years

When did you quit (if applicable)? ________________ Do you wish to quit? ❑ Yes ❑ No

How much alcohol do you drink weekly on average? ______________________________________

Have you ever felt you should cut down on your drinking? ❑ Yes ❑ No

Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No

Have you ever felt bad or guilt about your drinking? ❑ Yes ❑ No

Have you ever had a drink first thing in the morning? ❑ Yes ❑ No

Have you used illicit drugs? (marijuana, heroin, cocaine, LSD, etc.) ❑ Yes ❑ No

How much caffeine do you drink daily (include coffee, tea, soft drinks) ______________________

Have you ever had a blood transfusion? ❑ Yes ❑ No What year? ____________________

What is your marital status? ❑ Single ❑ married ❑ separated ❑ divorced ❑ widowed

Are you currently… ❑ employed ❑ unemployed ❑ retired

What is or was your occupation? ____

Please check the following behaviors you follow.

❑ Wear seatbelt ❑ Self-breast exam ❑ Smoke detector

❑ Wear helmet (while riding bike/motorcycle) ❑ Self-testicular exam ❑ Fire extinguisher

❑ Gun in house – if so, gun in safe/locks? ❑ Living Will or Advance Directive ❑ Regular exercise

Family History – (Please list anyone in your family with the following conditions)

Heart Disease ____

CABG (Heart bypass) ____

HTN ____

Diabetes ____

Stroke ____

Glaucoma ____

Mental Illness ____

Seizure Disorder ____

Bleeding Disorder/Blood Clots ____

Cancer (type) ____

Dementia ____

Other ____

Patient Name (Print) ____________________ Patient Signature ____________________ Date __________

Guardian/Parent Signature ____________________ Date __________

COMPREHENSIVE WELLNESS CENTER

Walter Rucker, MD
Cleveland, TN 37311
(423) 244-0311

New Patient Package Notifications and Releases

We want to welcome you to our practice. We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of ours, and yours. Please read them carefully and sign where indicated that you have read each statement.

General Consent for Treatment

We look forward to treating you as a patient. However, we need your permission for our physician(s)/practitioners to exam you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you.

I give general consent to be treated by Walter Rucker, MD

____ Patient or Guarantor/Date

Financial Policy/Assignment of Benefits

As a courtesy to our patients, the practice will accept assignment for some commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment for our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. If an account is turned over for collection, their fees, attorney's fees and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge responsibility for payment of fees for services provided by the practice and authorized the practice to release any medical information, if necessary, to my insurance company.

____ Patient or Guarantor/Date

Privacy Policy

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. If anyone else helps us with our internal operations, we will require them to keep any patient information they may see confidential. All other releases of information have to be specifically authorized by you. If you ask us to account for these release of information, we will provide that to you. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and seven years after your last visit. You will be given a form to sign which shows the details of to whom you wish to have your PHI (Protected Health Information) released.

I acknowledge that I have been informed about the privacy of my medical record.

____ Patient or Guarantor/Date

COMPREHENSIVE WELLNESS CENTER

Walter Rucker, MD

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name: ______________________ Birthdate: ______________

Address: ______________________ Phone: ______________

City: ______________________ State: ________ Zip: __________

FACILITY/PERSON(S) TO RECEIVE RECORDS

Comprehensive Wellness Center
2535 Georgetown Road NW
Cleveland, TN 37311
423-244-0311 Phone
615-216-8538 Fax

FACILITY/PERSON(S) TO RELEASE RECORDS

Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

City: ______________________ State: ________ Zip: __________

By initialing (please do **NOT** check mark) the spaces below, I specifically authorize the use and/or disclosure of the following medical records, if such information and/or records exist.

By placing my **INITIALS** in the applicable space next to the type of information, I authorize the following records to be released:

__________ Chart (Progress) Notes
__________ History and Physical
__________ Hospital Records
__________ Diagnostic/Lab Reports
__________ Other
__________ HIV/AIDS-related information
__________ Drug/Alcohol treatment
__________ Genetic testing information
__________ Mental Health information

Forms received without initials will be returned.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, this information described above my no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or on (insert applicable date or event) ______________ . I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

______________________________ ______________

(Signature of Patient/Guardian) (Date)

Family History for Common Hereditary Cancer Syndromes

Patient Name____________________ **Physician** ____________________

Date of Birth ____________________ **Date** ____________________

Have you previously had genetic testing (Example, BRCA) Y N

If yes, when?____________________ What were the results?____________________

Please circle Y to those that apply to **YOU** **<u>and/or</u>** **YOUR FAMILY** (on both **MOTHER** or **FATHER'S** side.) Please list your relationship to the individual diagnosed and the age at cancer diagnosis. This is a screening tool for the common features of hereditary cancer syndromes. Based on the family history information you provide here, you MAY be appropriate for genetic testing. Please consider the following family members:

YOURSELF, PARENTS, SIBLINGS, GRANDPARENTS, AUNTS, UNCLES, NIECES, & NEPHEWS

<u>BREAST AND OVARIAN CANCER</u>

		Relationship	Age at Diagnosis
Breast cancer at/or before age 50	Y N	________	________
Ovarian cancer at any age	Y N	________	________
Breast cancer in both breasts at any age	Y N	________	________
Male breast cancer at any age	Y N	________	________
2 breast cancers on the same side of the family with one diagnosed at/under 50	Y N	________ ________	________ ________
3 or more breast cancers on the same side of the family at any age	Y N	________ ________ ________	________ ________ ________
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N	________	________

<u>COLON AND ENDOMETRIAL (UTERINE) CANCER</u>

		Relationship	Age at Diagnosis
Endometrial (uterine) cancer before age 50	Y N	________	________
Colorectal cancer at/before age 50	Y N	________	________
Colorectal or endometrial (uterine) cancer at any age and two additional family members on the same side of the family with any cancer listed below*	Y N	________ ________ ________	________ ________ ________

*Colorectal, Endometrial, Ovarian, Stomach, Pancreatic, Kidney/ Urinary Tract, Brain, or Small Bowel

FOR OFFICE USE ONLY	
Candidate for testing?	Patient offered genetic testing
☐ Yes ☐ No	☐ Accepted ☐ Declined

Patient Signature __________ Date

Provider Signature __________ Date