Comprehensive Wellness Center
New Patient Information Form

Patient Information

Full Name: _____ Date of Birth: ____ / ____ / _____

Social Security # _____-_____-_____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave messages on your cell phone or home phone voicemail regarding results and/or appointment information? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired

Occupation: _____ Employer: _____

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: _____

List anyone you will allow us to talk to about your health.

Name: _____

Name: _____

Name: _____

Lifestyle Information

Do you smoke? ☐ Yes ☐ No

Do you vape? ☐ Yes ☐ No

Do you dip/chew tobacco? ☐ Yes ☐ No

For how long?: _____ Packs/day: _____ Quit date: _____

Do you want to quit? ☐ Yes ☐ No

Alcohol (drinks/week): _____ Illicit drugs: ☐ Yes ☐ No

Caffeine (cups/day): _____ ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

Have you ever had a blood transfusion? ☐ Yes ☐ No What year? _____

Immunizations (Date of Last Dose)

Tetanus: _____ Influenza: _____ Hepatitis B: _____ Shingles: _____

Prevnar 20: _____ Pneumovax: _____ MMR: _____ RSV: _____ COVID-19: _____

Preventive Exams (Last Exam Date)

Physical: _____ Eye: _____ Dental: _____ Gynecology: _____

Pap Smear: _____ Mammogram: _____ Prostate: _____ Testicular: _____

Colonoscopy: _____ Cologuard: _____ Chest X-Ray: _____ EKG: _____

Stress Test: _____ DEXA: _____

Advanced Planning

Do you have a Living Will? ☐ Yes ☐ No

Do you want info on a Living Will? ☐ Yes ☐ No

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

☐ Heart Disease: _____

☐ CABG (Heart bypass): _____

☐ Hypertension: _____

☐ Diabetes: _____

☐ Stroke: _____

☐ Glaucoma: _____

☐ Mental Illness: _____

☐ Seizure Disorder: _____

☐ Blood Clots/Bleeding Disorder: _____

☐ Dementia: _____

☐ Cancer – Type: _____

☐ Other: _____

Check if you are currently experiencing any of the following:

☐ Weight loss	☐ Fatigue	☐ Difficulty sleeping
☐ Weight gain	☐ Anxiety	☐ Loud snoring
☐ Headaches	☐ Depression	☐ Mood swings
☐ Dizziness	☐ Vision disturbance	☐ Hearing disturbance
☐ Nosebleeds	☐ Mouth sores	☐ Sore throat
☐ Tooth pain	☐ Chest pain	☐ Chest heaviness
☐ Chest tightness	☐ Palpitations	☐ Cough
☐ Wheezing	☐ Shortness of breath	☐ Leg swelling
☐ Abdominal pain	☐ Heartburn	☐ Food "stuck" with swallowing
☐ Painful swallowing	☐ Change in bowel habits	☐ Chronic diarrhea
☐ Chronic constipation	☐ Blood in stools	☐ 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: _____	

Medical Information

Allergies (medications, food, etc.):

Medical History (e.g., diabetes, hypertension, asthma):

Past Surgical History:

Other Providers You Are Seeing:

Preferred Pharmacy: _____

Medication List

Medication Name	Dosage (mg, mcg, units)	Times per Day	Prescribing Physician

Patient Signature: _____ Date: ___ / ___ / ____

Guardian/Parent Signature: _____ Date: ___ / ___ / ____

COMPREHENSIVE WELLNESS CENTER

Walter Rucker, MD
Lauryn Smith, NP-C
Michael Conar, PA-C
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 Comprehensive Wellness Center

_____ 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

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

FACILITY/PERSON(S) TO RECEIVE RECORDS

- ☐ Walter Rucker, MD
- ☐ Lauryn Smith, NP-C
- ☐ Michael Conar, PA-C
- ☐ Jill Brown, NP-C

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)

MyRisk™

Hereditary Cancer Test

Patient name: _____

Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know.

Do you have a personal history of:		
Breast, ovarian, colon, rectal, or pancreatic cancer at any age?	Yes	No
Uterine cancer at age 64 or younger?	Yes	No
Has any blood relative (parent, sibling, half-sibling, child, grandparent, grandchild, aunt/uncle, niece/nephew) been diagnosed with:		
Breast cancer at age 49 or younger?	Yes	No
Ovarian cancer at any age?	Yes	No
Has a parent, sibling, or child been diagnosed with:		
Pancreatic cancer at any age?	Yes	No
Colon or rectal cancer at age 49 or younger?	Yes	No
Endometrial cancer at age 49 or younger?	Yes	No

If you've answered "Yes" to any of the questions above, show this card to your healthcare provider today and ask to discuss hereditary cancer testing.