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 _____

Name _____ Birthdate_____ Date_____

Current Medications_____

_____

_____

_____

Drug Allergies_____

Please list **new diagnoses** since last visit

_____

Please list **procedures or testing** since last visit

_____

_____

What other **providers** do you see?_____

_____

Do you **smoke?** Yes No Do you **vape?** Yes No

Preferred Pharmacy:_____

Eye Exam Date_____ **Dental Exam** Date_____

Gynecology Exam Date _____ **Mammogram** Date _____ **DEXA** Date_____

Colonoscopy Date_____ **Cologuard** Date_____

Immunizations

Tetanus (due every 10 years)	Date of last one	_____
Influenza (Flu Shot)	Date of last one	_____
Hepatitis B Series	Date of last one	_____
Shingles (Shingrix)	Date of last one	_____
Prevnar 13 (Pneumonia)	Date of last one	_____
Pneumovax (Pneumonia)	Date of last one	_____

AAA Ultrasound (age 65-75 ex/current smoker) Date_____

Lung Cancer Screen (ex/current smoker over 55) Date _____

Do you have a **Living Will?** Yes No If not, would you like information on one? Yes No

Signature _____ Date_____

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
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

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.

Myriad genetics

Myriad Genetics / 320 Wakara Way, Salt Lake City, UT 84108.