Medical New Patient

Name:______________________________

Address:____________________________________

City:________________ State:____________ Zip:________________

Home Phone:_________________________

Mobile Phone:________________________

Date of Birth:________________ SSN:_____________________

Email:______________________________________

Emergency Contact:____________________________

Pharmacy Information

Preferred Pharmacy:__________________________________

Address:_______________________________________

City:_____________ State:______________ Zip________________

Phone Number:_______________________

5552 Franklin Pike, Suite 100
Nashville, TN 37220
Ph: 615-383-1246
Fax: 615-383-8260
Email: info@dunnwithpain.com

Please fill out form completely, if it does not apply to you put "None" next to the question.

What is your major symptom or complaint?

____

To what extent does this problem affect your daily activities (work, sleep, eating, etc)?

____

How long has it been since you first noticed any symptoms?

____

Has this become worse recently? Yes No Same Better Gradually worse

If yes, when and how?

____

If this is a recurrence, when was the first time you noticed this problem?

____

How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All Day Few hours Minutes

Is there anything you can do to relieve the problem? Yes No If yes, when and describe___________

____

If no, what have you tried to do that has not helped?______________________

What makes the problem worse? Standing Sitting Lying Bending lifting Twisting

other______________

Is the condition due to injuries or sickness arising out of employment? Yes No

Is the condition due to injuries or sickness arising out of an auto accident? Yes No

What kind of therapy have you tried?______________________

Medical History

Full name:________________ Date of birth:____________ Date:____________

Primary doctor:________________________________

Doctor who requested today's visit:________________________________

List current/previous doctors and their specialty:________________________________

____

ALLERGIES AND REACTIONS

____

____

____

____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

____

____

____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ☐ Alcohol/Drug addiction
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer (type):
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ ____________
- ☐ Crohn's disease
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis B or C
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Seizure
- ☐ Sexually transmitted disease (type): ____________
- ☐ Sickle cell disease
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ (Positive) TB skin test
- ☐ Ulcerative colitis
- ☐ Other:____________

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ☐ Adopted

Family Members		Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Mother				
Father				
Brothers and Sisters	1) ☐ M ☐ F			
	2) ☐ M ☐ F			
	3) ☐ M ☐ F			
Sons and Daughters	1) ☐ M ☐ F			
	2) ☐ M ☐ F			
	3) ☐ M ☐ F			

SOCIAL HISTORY

Occupation: | Marital Status: | Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No | How often? | How many drinks?

Do you smoke? ❑ Yes ❑ No | Packs per day: ❑ ¼ pack ❑ 1½ packs | How many years?___

Are you a former smoke? ❑ Yes ❑ No | ❑ ½ pack ❑ 2 packs | Year quit?___

Do you chew tobacco? ❑ Yes ❑ No | ❑ 1 pack ❑ Other:___

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?

Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:___ Last pap smear:___ Last mammogram:___

Last colonoscopy:___ Last prostate cancer screening:___ Last bone density scan:___

Immunizations: ❑ Pneumovax:___ ❑ Flu:___ ❑ Tetanus:___ ❑ Hep A:___ ❑ Hep B:___

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

❑ Weight gain	❑ Persistent cough	❑ Blood in stool	❑ Headaches
❑ Weight loss	❑ Chest discomfort	❑ Difficulty urinating	❑ Memory loss
❑ Night sweats	❑ Palpitations	❑ Trouble holding urine	❑ Numbness/Tingling
❑ Weakness	❑ Fainting	❑ Frequency of urination	❑ Tremor
❑ Fatigue	❑ Change in exercise tolerance	❑ Penis discharge	❑ Uncontrollable mood swings
❑ Insomnia	❑ Difficulty swallowing	❑ Vaginal discharge/bleeding	❑ Anxiety
❑ Change in hearing	❑ Indigestion or heartburn	❑ Nipple discharge	❑ Depression
❑ Change in vision	❑ Nausea	❑ Breast pain	❑ Skin Rash
❑ Runny nose	❑ Vomiting	❑ Breast lump	❑ Back pain
❑ Nose bleed	❑ Constipation	❑ Pain with intercourse	❑ Leg pain
❑ Fever	❑ Diarrhea	❑ Feeling too hot	❑ Leg swelling
❑ Blood in sputum	❑ Change in bowel habit	❑ Feeling too cold	❑ Other:___
❑ Shortness of breath	❑ Blood in vomit	❑ Dizziness	

Please list all your reason(s) for visiting today in order of priority:

1. ___

2. ___

3. ___

Patient/Designee signature | Patient name (PRINT) | Date | Time

Relationship to patient | Reason patient is unable to sign

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Medical Records Request

Patient Name:____________________________ DOB:_____________________ Date:_________

Requesting Provider:____

Records Provider:____

Fax:________________________ Phone:____________________________

Records Requested:____

Please fax records to:____

Please mail records to:____

I understand this authorization allows the release of all information in my medical records. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 1 calendar year from the date on this form.

Patient Signature:___________________________ Date:_____________

Clinic Representative_________________________

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Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for the patient with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known to the treating provider of whatever he or she is currently or previously suffering from.

I have read and understand the foregoing.

____

Patient's Signature Date

X-RAY QUESTIONNAIRE: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:____________________________

- There is a possibility that I may be pregnant at this time.
- Yes. I am definitely pregnant
- No, I am definitely not pregnant at this time
- I request that x-ray films not be taken at this time because____
____

Date of last menstrual period____________________

____

Patient's Signature Date

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We are pleased to take care of you today. If you are here for your medical exam or follow-up, please know we will be limited on what we are able to do today. If you have problems you wish to discuss, we will be respectful of your time by trying to accommodate your needs in one visit. Please know there will be an additional evaluation and management charge added to your account today if it exceeds the allotted time given for your appointment. Time consuming discussions and work-ups may be scheduled on a different date if time does not permit. We also want to be respectful of the other appointments scheduled for the day.

I have read and understand

X____________________________

Signature

Lab Disclaimer

- Most insurances do not and will not cover labs from an integrative provider or practice. To prevent the inconvenience of patients receiving large bills for labs that we have no control of once billed out, , we no longer submit labs through insurance for patients presenting for an Integrative Medicine Consult and/or visit.

- Most insurances do not cover hormone testing(ie. Estrogen, progesterone, testosterone, etc) and for that reason, we do not submit these labs through insurance.

- Because many insurances will only cover labs for a physical or yearly exam through a patients primary care provider or family practitioner, we only submit labs through insurance for yearly annual visits or physicals at a patients request. However, we will have the patient sign a disclaimer stating that any bill is their responsibility given that we can not guarantee insurance coverage.

- We offer a very affordable low cost lab menu with most full lab panel testing costing on average less than $150 with individual lab prices ranging between $5-$30 each.

- We offer blood type testing for $17.

- For individual labs drawn, a $10 supply fee is utilized (ie for patients coming in for single lab like testosterone). Three or more labs drawn simultaneously are not charged a lab supply fee.

- We do and will apply lab charges through HSA/FSA accounts.

- For those patients who still wish to put their labs through their insurance, we will fill out a prescription order to be taken to the lab of their choice where they can have it drawn and applied to insurance.

- For patients that utilize this practice as their primary care agent, we will apply their annual labs, as per their choice, through their insurance. However, we will require a disclaimer to be signed, prior to labs being drawn, removing us from responsibility if their insurance chooses to refuse payment.

- Any bill obtained due to insurance refusing payment for laboratory services is the responsibility of the patient and not the responsibility of the Dunn Clinic.

DUNN HEALTHCARE CENTER

JOSEPH BLYTHE, DO – SHELIA KNOX, PA-C – RAMIN SAEEDOUR, DC

Financial Policy

The following is an explanation of our clinics financial policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue-establishing, retaining and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

Payments

At Dunn Healthcare Center your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in attempt to assist you in meeting your financial obligations without increasing stress in your life.

-If you do not have health insurance or an HSA, then ALL payments are expected at the time of service.
-Pre-payment discounts or packages can be discussed.
-We can also discuss flexible payment arrangements.
-If you are using your health insurance, then ALL COPAYS & CO-INSURANCE are due at time of service.

-There will be a 1.5% finance charge added to all balances over 60 days past due.

-There will be a $25.00 charge on all returned checks.

** If you need any additional documentation other than a receipt please feel free to ask the front desk as we are able to provide that to you at no additional charge.

Insurance Coverage

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment or you will make payment arrangements with us to settle any outstanding balance that you owe Dunn Healthcare Center.

X-rays & Treatment Notes

We can release your X-rays and treatment notes to another doctor/ provider/ PCP/ or specialist, but you will need to sign an official release of records form. We require 48 hours notice to enable us to prepare and/or mail your records.

Appointment Policy

Dunn Healthcare Center is committed to providing all of our patients with exceptional care. Your appointments are very important to the Dunn Healthcare Center team of Staff and Physicians and they are reserved specifically for you. Therefore we respectfully request that you give us at least 24 hour prior notice (via telephone) for cancellations or rescheduling. Please note that when you forget, cancel or change your appointment without giving us enough notice, we miss the opportunity to fill that appointment time, and other clients miss the opportunity to receive care. A fee of $50.00 will be charged to your account for appointments that you no show, cancel or rescheduled without a prior 24 hour advance notice.

I have read and understand the above list of DUNN HEALTHCARE CENTER policies and regulations.

Patient signature ____________________ Date ______________

Patient's Printed Name ____________________

Patient Reminder Preferences

Welcome to the Dunn Healthcare Center! Our office has several different contact methods to remind you of your upcoming appointments. We would appreciate if you could please check and initial the method most convenient to you:

- ○ Email Reminder Only
- ○ Text Reminder Only
- ○ Email and Text Reminder
- ○ Reminder Appointment Card

Our typical reminder program will send a reminder one week prior to your appointment, if you confirm via email to this no secondary follow up reminder will be sent. If you do not confirm to the first email message, a reminder will be sent 2 days before your appointment. A final reminder will be sent 3 hours before your scheduled appointment.

The reminder messages are for your benefit. Your appointment will not be altered if you do not confirm.

Please do not reply to the text message. We DO NOT accept changes via email or text. To change or make an appointment, we ask that you call the office.

If you need changes made to this, please notify the front desk and we can accommodate your needs.

Thank you!

NAME : ______________________ DATE : ______________________

Covid19 Health Screening

1. Have YOU or anyone in your household had any of the following symptoms in the last 14 days;
Sore throat - Loss of smell / loss of taste - Fever at 100 or higher ☐ YES ☐ NO
Cough - Chills - Body aches for unknown reasons
Shortness of breath for unknown reasons - Gastrointestinal symptoms
Diarrhea for unknown reasons

2. Have you or anyone in your household tested positive + for Covid19 ? ☐ YES ☐ NO

3. Have you or anyone in your household cared for an individual in quarantine because of a positive +, or an assumed positive Covid19 test ? ☐ YES ☐ NO

4. Have you traveled to another City / State / Country in the last 14 days ? ☐ YES ☐ NO

5. To the best of your knowledge have you been in close proximity to any individual who has tested positive + to Covid19 in the last 14 days ? ☐ YES ☐ NO