PROVIDER: WRIGHT JERNIGAN, M.D.

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ____ /___ /_____
LAST FIRST MIDDLE

****ADDRESS:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE #: (_____)_____-_____ **WORK #:** (_____)_____-_____ **CELL#:**(_____) _____-_____

EMAIL ADDRESS : _____**SOCIAL SECURITY NUMBER:** _____-_____-_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

LANGUAGE: ☐ English ☐ Other: _____ **SEX:** ☐ Female ☐ Male

RACE/ETHNICITY: ☐ White ☐ African American ☐ Latino ☐ Other:_____ ☐ Decline to answer

PRIMARY CARE PHYSICIAN:_____**REFERRED BY:** _____

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

PREFERRED PHARMACY: _____(Name, City, State)

PREFERRED METHOD OF REMINDER CALLS *(check all that apply)*: ☐ Call home ☐ Call Cell ☐ Text Cell ☐ Email

RESPONSIBLE PARTY INFORMATION

If someone other than the patient is responsible for the medical bills, please list that information below:

NAME: _____ DOB: _____/_____/_____
LAST FIRST MI

SSN: _____

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐CHILD
☐OTHER_____

ADDRESS WHERE BILLS SHOULD BE SENT *(if different from patient's address)*:

_____

_____

Date: ____ / _____ /_____

MEDICAL HISTORY FORM

_____

Last Name First Name Date of Birth

_____

****Are you currently enrolled in hospice? □ Yes □ No If yes, which one? _____

Date of last mammogram: _____ / _____ / ___ □ Not applicable

Date of last colonoscopy: _____ / _____ / ___ □ Not applicable

PERSONAL MEDICAL HISTORY

Do <u>YOU</u> currently or have <u>YOU</u> had in the past:

	Y	N		Y	N		Y	N
Asthma (493.9)			High Cholesterol (272.0)			Hypothyroidism (244.9)		
COPD/Emphysema (496)			Hyperthyroidism (242.9)			Kidney Failure/Insufficiency (586)		
Coronary Artery Disease (414.00)			Congestive Heart Failure Myocardial Infarction (429.2)			Vascular Disease (specify): e.g. PVD, PAD, Veins, etc. (459.81)		
Diabetes (250.9)			Stroke/Mini-stroke (434.91)					
HIV/AIDS (042)			Bleeding/Blood Disorder (459.9)			Hepatitis A, B, C (070.1;070.30;070.70): (Circle One)		
Alcohol Abuse (303.90)			Gastrointestinal Problems (specify): (569.9)			Other medical problems (specify):		
Seizure Disorder (780.39)			Liver Problems (specify): (573.9)					
Cancer (type, location, date): (199.1)								
			Drug Abuse (304.90)					
Irregular heartbeat/A Fib (427.89)			High Blood Pressure(401.9)					

ALLERGIES: □ NONE

HEIGHT/WEIGHT

What is your approximate current weight: _____ lbs

Current Height: _____ft ____inches

Last Name First Name Date of Birth

MEDICATIONS:

I authorize Jernigan Surgery Clinic to access my electronic prescription medication history and use this information as part of my medical chart. □ Yes □ No *(please check one)*

If you marked yes above, please only list ***over the counter*** medications below:

*****Do you currently take a daily aspirin or another blood thinner? □ Yes □ No *(please check one)*

FAMILY MEDICAL HISTORY

Has any <u>FAMILY MEMBER</u> ever had (parent, child, sibling or grandparent):

HAS	Y	N	Relationship		Y	N	Relationship
Drug/Alcohol Abuse				High Cholesterol			
Diabetes				Thyroid Disease			
Kidney Disease				Bleeding/Blood Disorder			
Heart Disease				Stroke			
High Blood Pressure				Obesity			
GI/Stomach Disease				Other:			
Cancer (type):							

SOCIAL HISTORY

Have you ever smoked? □ Yes □ No
Do you currently smoke? □ Yes □ No
If yes:
How many packs per day do you smoke? _____

SURGICAL HISTORY

Surgery	Mo/Year	Surgery	Mo/Year

SELF PAY PATIENT POLICIES

The cost of your first consultation will be $100, payable before the doctor will see you. At that time, it will be determined whether a surgical procedure is required. One of the following will then happen:

- **No surgical procedure, but follow up visit.** In this case, the follow up visit will be $50, also payable before the doctor will see you.
- **Test or Procedure in our office.** You will be notified prior to your test/procedure as to what your out of pocket expense will be. Your cost will include a 40% discount off of our regular fee for insurance companies. You will be required to pay 100% of that expense prior to your test/procedure. There will be no charge for one follow up visit with the doctor. Any further appointments for the same diagnosis will be $50.
- **Hospital/Surgery Center Surgery.** The hospital/surgery center will contact you to review their charges prior to your surgery. ***These fees are separate from the doctor's fee and will appear on a bill from our office***. We will notify you of our estimated charges and you will be required to pay 50% of the total prior to your surgery. These fees will also include a 40% discount off of our regular fee for insurance companies. You may set up a payment plan with our office, but this must be done prior to your surgery. The payment plan may not exceed six (6) months and must be set up on automatic bank draft from either a checking account or credit card. We offer CareCredit if you need longer than 6 months. If payment is not made according to the agreed upon payment plan, your account may be turned over to our collection agency and a 50% collection fee added to your total balance.

All payments must be in the form of cash, cashier's check, money order or credit card. No personal checks will be accepted.

I have read the above and agree to the terms.

_____ _____

Patient, Parent or Guardian Signature **Date**

Should you have any questions, please call our office manager, Samantha Jernigan at 731-884-0002.

Revised 9/16

OFFICE POLICIES – SELF PAY PATIENTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received or have been given the opportunity to receive a copy of Jernigan Surgery Clinic, PLLC Notice of Privacy Practices.
(copies are available at reception desk)

_____
Initial

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

SIGNED: _____ **DATE:** _____
Patient Responsible Party

AUTHORIZATION FOR RELEASE OF PRESCRIPTION MEDICATIONS

I authorize Jernigan Surgery Clinic to access my prescription medication history and use this information as part of my medical chart.

_____
Initial