Surgical Alliance of Middle Tennessee

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ GENDER M / F MARITAL STATUS ____

SSN _____ HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

REFERRING PHYSICIAN _____ PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____

EMPLOYER _____ WORK PHONE _____

NEAREST RELATIVE _____ RELATIVE'S PHONE _____

DO YOU HAVE A LIVING WILL? _____ PHARMACY/ PHONE# _____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE COVERAGE YES NO ***SPECIALIST*** CO-PAY AMOUNT _____

PRIMARY INS _____ INSURED'S NAME _____

POLICY HOLDER _____ DOB _____ SSN _____

POLICY HOLDERS ADDRESS (if different than above) _____

CITY _____ STATE _____ ZIP _____ PHONE _____

INSURANCE ID # _____ GROUP _____

SECONDARY INS _____ INSURED'S NAME _____

POLICY HOLDER _____ DOB _____ SSN _____

POLICY HOLDERS ADDRESS (if different than above) _____

CITY _____ STATE _____ ZIP _____ PHONE _____

INSURANCE ID # _____ GROUP _____

BY SIGNING BELOW, I AGREE TO ALLOW SURGICAL ALLIANCE OF MIDDLE TENNESSEE TO RELEASE ANY INFORMATION TO MY INSURANCE CARRIER TO FILE MY INSURANCE. I ALSO AGREE TO PAY MY CO-PAYMENTS AND ALL AMOUNTS APPLIED TO DEDUCTIBLE/ COINSURANCE. IF MY ACCOUNT IS SENT TO COLLECTIONS, I ALSO AGREE TO PAY FOR COLLECTION CHARGES AND ASSOCIATED FEES INCLUDING ATTORNEY AND COLLECTION AGENCY FEES.

PATIENT SIGNATURE _____ DATE _____

Contact Information

Patient Name:	Date of Birth:_____ Age:___ Gender: ☐ M ☐ F
Phone #1:_____ Best time to Call: AM/PM May we leave a message? ☐ Yes ☐ No	Phone #2:_____ Best time to Call: AM/PM May we leave a message? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Personal History

	Yes	No		Yes	No
Have you or a family member ever had a problem with anesthesia?	☐	☐	Do you live alone?	☐	☐
Do you have metal anywhere in your body (plates, screws, joint replacements, and vascular stents)?	☐	☐	Do you need help with your normal daily activities?	☐	☐
Have you ever been diagnosed with sleep apnea?	☐	☐	Do you use a wheelchair, walker or cane on a regular basis?	☐	☐
Do you use a CPAP machine?	☐	☐	Do you have any culture or religious practices that are important to you during your visit with us? _____	☐	☐
Do you have a Living Will or Advance Directive?	☐	☐	Would you accept blood products/transfusion if needed?	☐	☐
Do you have Home Health visiting you at present?	☐	☐	Do you smoke? Packs/Day_____ How many yrs?_____	☐	☐
Do you ever feel threatened by your partner, child, caregiver or anyone in your home?	☐	☐	Do you drink alcohol? How much?_____ How often? _____	☐	☐
Do you have any physical restrictions?	☐	☐	Do you use recreational drugs? Specify:_____	☐	☐

What would you consider your level of activity to be? ☐ Very Light ☐ Light ☐ Moderate ☐ High	How do you like to learn new things? ☐ Reading ☐ Watching ☐ Listening ☐ Doing
What pharmacy do you use?	Primary Care Physician:

Past Surgery Check all that apply

☐ **NONE**	☐ Colonoscopy/EGD	☐ Kidney Removal	☐ Total Hip	Other
☐ Aneurysm (AAA)	☐ Colon Resection	☐ Cystoscopy	☐ Left ☐ Right	
☐ Angiogram (other than heart)	☐ Appendectomy	☐ Prostate	☐ Total Knee	
☐ Heart Bypass	☐ Gallbladder	☐ Lithotripsy	☐ Left ☐ Right	
☐ Heart Cath/Stents	☐ Hernia	☐ D & C	☐ Arthroscopy	
☐ Pacemaker/Defibrillator	☐ Hemorrhoidectomy	☐ Hysterectomy	☐ Knee ☐ Shoulder	
☐ Fem/Pop Bypass	☐ Laparoscopy	☐ Tubal Ligation	☐ Foot, Ankle or Knee	
☐ Heart Valve	☐ Breast Biopsy	☐ Cesarean Section	☐ Hand or Wrist	
☐ Carotid ☐ Left ☐ Right	☐ Mastectomy	☐ Spine (Back/Neck)	☐ Shoulder or Elbow	
☐ Silverhawk	☐ Left ☐ Right	☐ Spinal Injections	☐ Carpel Tunnel Release	
☐ AV Grafts	☐ Amputation	☐ Cataract	☐ Ear tubes	
☐ Gastric Bypass	☐ Splenectomy	☐ Left ☐ Right	☐ Sinus	
	☐ Bladder Repair	☐ Ablation	☐ Tonsils and Adenoids	
			☐ Thyroid	

Personal Medical History: Do you have now or have you ever had any of the following symptoms or conditions? If yes, please check box. If no conditions or symptoms in a category please check **NONE**.

Cardiovascular

- ☐ **NONE**
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Heart Attacks/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Ankle Swelling
- ☐ Irregular Heart Beat
- ☐ Blood Clots/DVT
- ☐ Angioplasty/Stents
- ☐ Congenital Heart Problems
- ☐ Coronary Artery Disease

Name of Cardiologist: _____

Date of Last Visit: _____

Date of most recent EKG: _____

Respiratory

- ☐ **NONE**
- ☐ Recent Respiratory Infection
- ☐ Short of Breath with Exertion
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/ COPD
- ☐ Pulmonary Emboli
- ☐ Use O2 at Home _____L/min
- ☐ Tuberculosis

Musculoskeletal

- ☐ **NONE**
- ☐ Arthritis/Gout
- ☐ Muscular Dystrophy
- ☐ Difficulty Walking
- ☐ Fibromyalgia
- ☐ Foot Problems

Kidney

- ☐ **NONE**
- ☐ Prostate Problems
- ☐ Blood in Urine
- ☐ Frequent Infections
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Frequent Urination, Urgency or Leakage

Digestive

- ☐ **NONE**
- ☐ Indigestion
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Ulcers

Neuro

- ☐ **NONE**
- ☐ Seizures
- ☐ Stroke/Mini Stroke
- ☐ Paralysis/Weakness
- ☐ Neuropathy/Numbness
- ☐ Back Pain/Neck Problems
- ☐ Frequent headaches/ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Alzheimer's Disease
- ☐ Multiple Sclerosis

Cancer

- ☐ **NONE**

Type_____

- ☐ IV Chemo
- ☐ Oral Chemo
- ☐ Radiation
- ☐ Surgery

Endocrine

- ☐ **NONE**
- ☐ Thyroid Disease
- ☐ Diabetes
  - ☐ Pills ☐ Insulin
  - ☐ Pump ☐ Diet Controlled

Hematological

- ☐ **NONE**
- ☐ Anemia
- ☐ Bleeding Disorder/ Disease
- ☐ Previous Blood Transfusion

Skin

- ☐ **NONE**
- ☐ Sore that won't heal
- ☐ Open Wound
- ☐ Wound Care Patient
  - ☐ Current ☐ Past

Females Only

Last menstrual cycle_____

- ☐ I had a hysterectomy
- ☐ I am Post-Menopausal

Infectious Diseases

- ☐ **NONE**
- ☐ History of Wound Infection
- ☐ HIV
- ☐ Hepatitis Type: _____
- ☐ MRSA

When? _____

- ☐ VRE

Implantable Devices

- ☐ **NONE**
- ☐ Ports/Pumps
- ☐ TENS unit/Medication pump
- ☐ Other _____

Important!
Bring implant card with you

Eyes

- ☐ **NONE**
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ History of retinal detachment
- ☐ Blindness/Macular Degeneration

Ears/Nose/Throat

- ☐ **NONE**
- ☐ Ear Problems
- ☐ Loss of hearing
- ☐ Loss of balance
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Sinus Problems

Family Medical History (close blood relatives)

- ☐ **NONE**
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Mental Illness
- ☐ Neurological Disease
- ☐ Cancer-Type:_____

Other:_____

* PRN medications must have indications completed

Circle **C** to continue or
Circle **DC** to discontinue

MED HISTORY RECORDED BY: DATE/TIME:

- *List below all of the patient's medications prior to admission including OTC, vaccines, & herbal meds, etc.*
- *New medications or medication changes should be written on admission orders.*

MEDICATION NAME	DOSE	ROUTE	FREQUENCY	INDICATION	LAST DOSE ADMINISTERED	NURSE RECONCILED (Initial Box)	PHYSICIAN ORDER ONLY Admission	Transfer	Discharge
1.							C DC	C DC	C DC
2.							C DC	C DC	C DC
3.							C DC	C DC	C DC
4.							C DC	C DC	C DC
5.							C DC	C DC	C DC
6.							C DC	C DC	C DC
7.							C DC	C DC	C DC
8.							C DC	C DC	C DC
9.							C DC	C DC	C DC
10.							C DC	C DC	C DC
11.							C DC	C DC	C DC
12.							C DC	C DC	C DC
13.							C DC	C DC	C DC
14.							C DC	C DC	C DC

Disclaimer: This document does not replace the assessing practioner's responsibility to review all medications (Rx & OTC), health supplements, & allergies with the patient.

ALLERGIES: ❑ NKDA	REACTION	ALLERGIES:	REACTION
1.		4.	
2.		5.	
3.		6.	
Pharmacy 1/Phone: ( )		**Pharmacy 2/Phone:** ( )	

Source/Use of Home Medications: (check all that apply)

❑ Patient ❑ Family ❑ Caregiver recall
❑ Primary care physician list / PCHIS
❑ Medication Admin. Record from facility
❑ Previous discharge paperwork
❑ Unable to Obtain - Reason:

❑ Patient medication list
❑ Prescription Bottles
❑ Pharmacy
❑ Other:

❑ Home Meds Sent Home With:_____

❑ Home Meds Sent to Pharmacy:_____

Reconciled/Verified with MD:

Sign and date if to be used as order.

Time: ____ / **Date:** ____ **RN Signature** (Admit):_____ **Time:** ____ / **Date:** ____ **MD ADMIT ORDERS:**_____

Time: ____ / **Date:** ____ **RN Signature** (Transfer):_____ **Time:** ____ / **Date:** ____ **MD TRANSFER ORDERS:**_____

Time: ____ / **Date:** ____ **RN Signature** (Discharge):_____ **Time:** ____ / **Date:** ____ **MD DISCHARGE ORDERS:**_____

NorthCrest Medical Center

NorthCrest Home Medication & Reconciliation Form

Physician Order Form

Permanent Chart Document

Patient Sticker

NC-3019 (Rev.9/13)

SURGICAL ALLIANCE PRIVACY POLICY

AND

CONTACT INFORMATION SIGNATURE SHEET

Notice of Privacy Practices

By signing below I indicate that I have been given the opportunity to review and receive a copy of the Privacy Practice Policy of Surgical Alliance of Middle Tennessee.

Contact Information

Patient Name: _____

Email Address: _____

Home telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message.
- ☐ Do not leave messages at this number.

Work telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message.
- ☐ Do not leave messages at this number.

Cell telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message by voice or text.
- ☐ Do not leave messages at this number.

Written communication

- ☐ Okay to mail sensitive information to my house.
- ☐ Okay to E-mail sensitive information.
- ☐ Send all written communications to my P. O. Box.

Disclosing your health information to other individuals:

- ☐ DO NOT release any information to anyone except me. (This includes your spouse, parent, etc.)
- ☐ You have my permission to disclose information to the following person(s):

_____ _____

_____ _____

Patient/Guardian Signature: _____ Date: _____

Authorization to Release Medical Records

Print Patient's Name _____ Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

I request and authorize: **Surgical Alliance of Middle Tennessee, PLC**
417 NorthCrest Drive
Springfield, TN 37172

Phone: (615) 384-8211
Fax: (615) 384- 8502

☐ To Provide to: ☐ To Receive from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

For the purpose of: Continued medical care (please include name and address of physician you will be seeing) Moving Personal use other

Method of Delivery (please circle one): Fax Mail Hold for pick up

Records Requested:

☐ All available records
Operative Reports
Laboratory Results
History and Physicals
Hospital Admissions
Other _____
Medical Imaging
Pathology Reports

_____
Patient Signature Date

Faxed By: Date: