Patient Registration

Welcome to our office. We look forward to establishing a comfortable and secure relationship with you. You are important to us and we want you to feel special every time you call or walk into this office. Please take a few minutes to read and complete this form. This information is necessary to make sure you receive the best care during your visit and to minimize any misunderstanding which may occur due to incorrect or incomplete information.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Best Phone: _____ Secondary Phone: _____

email: _____

DOB: _____ Age: _____ Social Security #: _____ / _____ / _____ Sex ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Address: _____ Phone: _____

Reason For Today's Visit: _____

INSURANCE INFORMATION

Insurance And Responsible Party Information: ☐ SELF ☐ SPOUSE ☐ PARENT *If other than self please fill out the following information:*

Insurance Carrier: _____ Primary Card Holder: _____ DOB: _____

Social Security #: _____ / _____ / _____ Relation: _____

ETHNIC BACKGROUND INFORMATION (Required by Healthcare Legislation)

RACE: ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ African American ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Printed Legal Name: _____ **Signature:** _____

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

NASHVILLE SURGICAL ASSOCIATES

Revised 11.2.2020

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Ray HARGREAVES, MD ✦ Jonathan COHEN, MD ✦ Brian SHEA, MD

Name: _____ Today's Date: _____ Age: _____ DOB: _____

Referring Provider: _____ Primary Care Physician: _____

Cardiologist: _____ GI: _____ OB/GYN: _____

FOR MD ONLY _____

Occupation: _____ Are You A Jehovah's Witness? ☐ No ☐ Yes

REASON FOR TODAY'S VISIT: _____

List any PAST MEDICAL PROBLEMS:

_____

_____

_____

List any SURGERY OR MEDICAL PROCEDURE(s):

_____

_____

_____

What MEDICINES do you take? *Please include vitamins, supplements, and OTC medicine.* LIST DOSAGE.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

List MEDICATION AND FOOD ALLERGIES

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Have you ever had MRSA? ☐ No ☐ Yes If "yes, when?: _____

Do you currently **SMOKE**? ☐No ☐Yes If "yes," how many packs per day?: _____

Have you ever been a smoker? ☐No ☐Yes If "yes," for how many years?: _____ When did you quit?: _____

If you use alcohol, how many alcoholic beverages do you consume per week?: _____

Have you ever had a problem with drinking too much alcohol? ☐ No ☐ Yes

When was your last Flu immunization?: _____ Pneumonia immunization?: _____

FAMILY HISTORY: please list the family relation according to the following conditions *(i.e. Crohn's Disease: paternal uncle)*

Cancer: _____ Stroke: _____ Diabetes: _____ Heart Disease: _____

Gastrointestinal Disorder: _____ Crohn's Disease: _____ Ulcerative Colitis: _____

TO BE COMPLETED BY OFFICE MEDICAL ASSISTANT

Blood Pressure: _____ Weight: _____ Height: _____

Please complete the opposite side

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PLEASE CHECK ANY OF THE FOLLOWING IF YOU HAVE/HAD:

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Loss

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Vision Change
- ☐ Diabetic Retinopathy

- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Nosebleeds
- ☐ Obstructive Sleep Apnea
- ☐ Mass/Lesion of Mouth
- ☐ Voice Change
- ☐ Head or Neck Cancer

- ☐ Chest Pain/Pressure
- ☐ Exercise Intolerance
- ☐ Fainting
- ☐ Heart Attack
- ☐ Heart Rhythm Problem
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Leg Pain with Walking
- ☐ Leg Swelling
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Heart Procedure (Stent/Bypass)
- ☐ Shortness of Breath

- ☐ Asbestos Exposure
- ☐ Aspiration
- ☐ Asthma or COPD
- ☐ Cigarette Smoking
- ☐ Collapsed Lung
- ☐ Lung Surgery
- ☐ Chronic Coughing
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Lung Cancer
- ☐ Pneumonia
- ☐ Tuberculosis Exposure

- ☐ Abdominal Pain
- ☐ Bloody or Dark Stool
- ☐ Chronic Nausea
- ☐ Chronic Vomiting
- ☐ Cirrhosis/Hepatitis
- ☐ Liver Disease
- ☐ Incontinence of Stool
- ☐ Pancreatitis
- ☐ Ulcer
- ☐ Vomiting Blood
- ☐ Yellowing Skin/Eyes
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ Gastroesophageal Reflux
- ☐ Hemorrhoids
- ☐ Irritable Bowel
- ☐ Spastic Colon
- ☐ Anal Surgery/Disease

- ☐ Change in Skin Color
- ☐ Keloid
- ☐ Mole Change
- ☐ Skin Cancer

- ☐ Blood in the Urine
- ☐ Cancer of Urinary Organs
- ☐ Erectile Dysfunction
- ☐ Genital Lesion
- ☐ Female Cancer/Surgery
- ☐ Kidney Failure
- ☐ Kidney/Bladder Stones
- ☐ Polycystic Kidney Disease
- ☐ Prostate Enlargement
- ☐ Prostate Surgery
- ☐ Urinary Incontinence
- ☐ Urinary Infection/Cystitis
- ☐ Urinary Retention
- ☐ Urinary Tract Obstruction

- ☐ Hernia
- ☐ Arthritis
- ☐ Joint Complaints
- ☐ Osteoporosis

- ☐ Headache
- ☐ Herniated Disc
- ☐ Sciatica
- ☐ Memory Loss
- ☐ Parkinson's Disease
- ☐ Seizure
- ☐ Stroke or TIA

- ☐ Adrenal Gland Disorder
- ☐ Diabetes
- ☐ Parathyroid Disease
- ☐ Pituitary Gland Disorder
- ☐ Thyroid Disease
- ☐ Thyroid Surgery

- ☐ Abnormal Bleeding
- ☐ Abnormal Bruising
- ☐ Anemia
- ☐ Low Blood Count
- ☐ Blood Clotting Disorder
- ☐ Disease of Blood Cells
- ☐ Lymph Node Enlargement

- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Psychosis

- ☐ Scleroderma
- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ HIV or AIDS
- ☐ Lupus
- ☐ Sarcoidoisis

Please list any additional information: _____

_____

_____

_____

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