MR#

PAST MEDICAL HISTORY

HOSPITALIZATIONS: (REASON/DATE)

_____
_____
_____
_____
_____
_____

SURGERY: (*circle all that apply)*
APPENDIX • GALLBLADDER • HYST •
HEART • COLON • BOWEL • BACK
GASTRIC BY-PASS • THYROID • TUBAL LIGATION
OTHER:_____
_____
_____

IMMUNIZATIONS: (Indicate year of last dose)
Tetanus_____ Influenza_____
Pneumonia_____

TOBACCO: (*circle all that apply)*
Currently Smoke Never Smoked Dip Chew
Quit Smoking(date_____) Smoke___packs/day

ALCOHOL: (*circle all that apply)* Never Social Daily Light Moderate Heavy

ALLERGIES TO MEDICATION:

_____
_____
_____

OTHER ALLERGIES: (ie, food, pollen, bee stings)_____

PRESENT MEDICATIONS; (Name and Dose)_____
_____
_____
_____

PRIMARY CARE PROVIDER:_____ OTHER MD'S:_____
_____

FAMILY HISTORY: (If any blood relative has suffered from the following? - Please indicate which relative)

Hypertension_____
Diabetes_____
Epilepsy/Seizure_____
Arthritis_____
Stroke/CVA_____
Mental Illness_____
COPD_____

Heart Disease_____
Cancer_____
Thyroid_____
Migraines_____
Tuberculosis_____
Asthma_____
Other:_____

MEDICAL HISTORY: (Have you ever had any of the following? √ Y for "yes" N for "no". **PLEASE ANSWER EVERY QUESTION)**

ILLNESS	Y	N		Y	N		Y	N
ASTHMA			ARTHRITIS			ALCOHOL ABUSE		
ANEMIA			BACK PROBLEMS			BIPOLAR DISORDER		
BLEEDING DISORDER			BRONCHITIS			BONE FRACTURE		
CANCER			↑CHOLESTEROL			CONGESTIVE HEART FAILURE		
CROHNS			DEPRESSION/ANXIETY			DIABETES		
DIVERTICULOSIS			DRUG ADDICTION			ECZEMA/PSORIASIS		
EMPHYSEMA			FIBROMYALGIA			GERD (REFLUX)		
GLAUCOMA			GOUT			HEAD INJURY		
HEART ATTACK (MI)			HEPATITIS			HIV/AIDS		
HYPERTENSION			IBS			KIDNEY DISEASE/STONES		
LIVER DISEASE			MIGRAINE HEADACHES			PANCREATITIS		
STD(sexually transmitted disease)			STROKE (CVA)			THYROID DISORDER		
TUBERCULOSIS								

_____ _____ _____ _____
Patient or Guardian Signature & Relationship to Patient Today's Date Review Date Review Date

_____ PHARMACY:_____
PATIENT NAME ADDRESS:_____

CHART #_____ ***EVERY SECTION MUST BE COMPLETED***

DoctorsCare Patient Registration Form Occupational Medicine

Name _____Date of Birth_____

Age ____ Sex ____ Race____ Ethnicity_____ Preferred Language_____

Social Security Number_____

Home phone _____Cell phone_____

Address_____APT#_____

City, State, andZip_____

Employer_____WorkPhone_____MaritalStatus_____

ImmediateSupervisor_____Workphone_____

EmergencyContact_____Phone_____

WORKERS' COMPENSATION PATIENTS ONLY

Date of Injury_____ Employment Related- Yes_____ No_____

Where did the injury occur? _____

How did the injury happen? _____

Employee/employer who verified this information _____

Permission/Assignment Release

In the event the claim for workers' compensation declared fraudulent for this illness or condition or it is determined by the Workers' Compensation Board that the illness or injury is not a compensable workers' compensation case, I_____, agree to pay the physician's fee for services rendered.

I have been informed that I am responsible to pay for any services rendered by DoctorsCare with regard to the discovery and treatment of any condition not related to the workers' compensation injury or illness. I agree to pay for all services not covered by workers' compensation or my (private) group health insurance and all charges for treatment and personal items unrelated to my workers' compensation illness or injury._____ (Initial)

I hereby authorize you to provide necessary medical treatment. I authorize that my insurance benefits be paid directly to **DoctorsCare.** I accept financial responsibility for all unpaid services and authorize **DoctorsCare** to release information as required for patient care and billing purposes. If I should fail to pay my balance, I agreed to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less that 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and DoctorsCare referral of your account to said collection agency. **I agree that this authorization shall be valid until rescinded in writing, when the information is released in reliance upon this consent.** A photocopy of this assignment shall be considered as valid as the original. I have read and fully understand the terms thereof.

Patient OR GuardianSignature_____Date:_____

REV 6/12/13

DoctorsCare

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a worker's compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKER'S COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize

_____
(Name of Medical Provider)

to furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation . An employer's representative may include, but is not limited to, a case manager, claims manager or any employer agent having a legitimate need to know my medical information. I realize that good communication between the medical provider, employer and employer's representative is necessary to address worker's compensation treatment issues.

I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20_____.

_____ _____
Patient Social Security last four numbers

_____
Witness

By signing this consent, you are agreeing that DoctorsCare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to DoctorsCare to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____ Date: _____
Relationship to Patient: