Lakeside Clinic
2337 Homer Clayton Drive
Guntersville, AL 35976

Patient: Name (Last – First - Middle		Sex: □ Male □ Female	Patient Date of Birth:	Age:
Address (Street – City – State – Zip)		Patient Social Security Number:		
		Marital Status: □ Single □ Married □ Divorced □ Widowed		
		Driver's License Number:		
Landlord (if renting)	Landlord's Phone Number:	Home Phone Number:		
Name of Employer:		Occupation:	Work Phone Number:	
Name of Spouse (Last – First – Middle)		Date of Birth:	Spouse's Phone Number:	
Nearest Relative Not Living with You		Relationship:	Relative's Phone Number:	
Nearest Friend Not Living with You		Friend's Phone Number:		
In Case of Emergency, Notify		Emergency Contact's Phone Number:		
Whom May we Thank for Referring You to Us?		Phone Number:		
Family Physician		Phone Number:		
Family Dentist		Phone Number:		
Current Pharmacy (City & State)		Mail Order Pharmacy:		
Who is Financially Responsible for Payment?		I will be paying today by: □ cash □ check □debit/credit card		
I understand and agree that I am ultimately responsible for payment. I certify this information is true and correct to the best of my knowledge: _____				

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DUE TO THE PRIVACY AND CONFIDENTIALITY ACT, please list the people that you approve to have access to your information as stated below:

Appointment Scheduling: _____ Relationship: _____

Billing Information: _____ Relationship: _____

Medical Records Information: _____ Relationship: _____

AUTHORIZATION TO LEAVE MESSAGES:

I authorize Lakeside Clinic physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, and medications on my home answering machine or voicemail. This authorization will be in effect until I have given written notice to Lakeside Clinic.

Agree: _____ Disagree: _____

AUTHORIZATION TO CONTACT EMPLOYMENT:

I authorize Lakeside Clinic physicians and staff to leave messages at my workplace if they are unable to leave a message at my home number for any reason. I may revoke this authorization by giving written notice to Lakeside Clinic.

Agree: _____ Disagree: _____

Signature: _____ Date: _____

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Guaranty of Payment for Medical Services

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Mastercard, and Visa. We will be happy to file most primary insurance for you as a courtesy. Changes in insurance information should be communicated with our office as soon as possible.

However, you must realize:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are covered by all insurance contracts.
3. We may need to release medical information concerning you to your insurance carrier as part of the processing of your claim. By signing this form, you consent to the release of such information for that limited purpose.

We must emphasize that as your medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. All copays are due at the time of service. There is a $20.00 fee for returned checks.

Accounts over 90 days past due may be turned over to an agency for collection, unless payment arrangements have been made with this office. Your future status with this office will be considered at such time.

By signing this form, you agree that you will be responsible for the reasonable costs, to include attorneys' fees and interest, we incur if your account becomes past due and is turned over for collections.

We value you, our patient, and will continue to provide you with the best professional care.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient Signature: _____ Date: _____

JOEL C. MILLIGAN, M.D.
Diplomate of American Board of Family Practice
ALEX NIXON, M.D.
Diplomate of American Board of Family Practice
MARK CHRISTENSEN, M.D.
Diplomate of American Board of Family Practice
JOSHUA BELL, M.D.
Diplomate of American Board of Family Practice

LAKESIDE CLINIC, LLC

2337 Homer Clayton Drive
Guntersville, AL 35976
Telephone (256) 582-5131
Fax (256) 582-1100

LEZLIE REED-JOHNSON, M.D.
Diplomate of American Board of Family Practice
JOHN W. BOGGESS, M.D.
Diplomate of American Board of Family Practice
JEFF SAYLOR, M.D.
Diplomate of American Board of Family Practice

Authorization for Release / Request of Protected Health Information

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's phone #: ( ) _____

Date of Request: _____ Date Needed: _____

❑ I authorize Lakeside Clinic, LLC to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

OR

❑ I authorize Lakeside Clinic, LLC to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

Purpose For This Request: (Check one) ❑ Healthcare ❑ Insurance coverage ❑ Personal ❑ Other

Type Of Records Requested: (Check one)

❑ Specific Information (Select one or more, as applicable)

- ❑ Operative report
- ❑ Laboratory test results
- ❑ Office Notes
- ❑ History & Physical
- ❑ X-ray reports
- ❑ DEXA Results
- ❑ Consult
- ❑ Discharge Summary
- ❑ Other _____

❑ All medical records related to a specific illness or injury

❑ All medical records

_____
Specify illness / injury — Date(s) of treatment

AUTHORIZATION VALID FOR THIS REQUEST ONLY

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

_____ _____
Signature of patient or legal representative — Date

If signed by legal representative, relationship to patient: _____

_____ _____
Witness — Date

LAKESIDE CLINIC, LLC
2337 Homer Clayton Drive
Guntersville, AL 35976

DOB: _____

Personal / Social Hx – Age 13 to Adult

Patient Name: _____
Drug and Food Allergies and Indicate Reaction: _____
Reason for Today's Visit: _____
Have you ever had a blood transfusion? ☐Yes ☐No
Have you had any recent infection, illness or injury? _____
Last doctor: _____ Reason for leaving: _____
Other doctors/specialists involved in your care: _____

Race / Culture: ☐African American ☐Caucasian ☐Hispanic ☐Asian
☐Native Hawaiian or Pacific Islander ☐Other
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced (# times: ____)
Do you have children? (list genders & ages)_____
Where do you live? (house , apartment, nursing home, etc.) _____
Who do you live with? (include all) _____
What activities do you have trouble doing by yourself?

☐Eating	☐Dressing	☐Going to the bathroom	☐Walking
☐Bathing	☐Getting out of bed	☐Grooming	☐Communicating
What activities are you NOT able to do?		☐Manage household	☐Shopping
☐Lifting	☐Cooking	☐Housecleaning	☐Laundry
☐Managing medications	☐Managing money	☐Manage home repair	☐Driving
☐Use public transportation		☐Reading	☐Writing

Current Job/Position: _____
Religious Preference: _____
Do you use tobacco? ☐Cigarettes ☐Chewing ☐Snuff Packs per day _____ Number of years used _____
Were you previously a smoker? ☐Yes ☐No If so, year you quit _____ and # of years you smoked _____
Do you live in a house with a smoker? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No Type & Amount: _____
Do you use drugs? ☐Yes ☐No If yes, what kind and how often? _____
Do you exercise regularly? ☐Yes ☐No If yes, what kind of exercise and how often? _____
Do you use a seatbelt? ☐Yes ☐No Do you use a helmet for biking/skateboarding? ☐Yes ☐No ☐NA
Activities / Hobbies / Sports: _____
Education Completed: ☐GED ☐High School ☐Tech School
☐College ☐Post Grad ☐Other: _____
Are you enrolled in: ☐Public School ☐Private School ☐Home school School Grade: _____
Name of School/ College attending: _____

Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

GENERAL

☐Fever	☐Chills	☐Feeling Tired
☐Weakness	☐Weight Loss	☐Weight Gain

SKIN/HAIR/NAILS/LYMPH

☐Change in Skin Color	☐Easy Bruising	☐Pitted Nails
☐Dry Skin	☐Skin Lesions	☐Mole Changes
☐Rash	☐Hair Symptoms	☐Lesions
☐Itching	☐Fingernail Discoloration	☐Swollen Lymph Nodes

JOINTS/MUSCLES

☐Muscle Aches	☐Localized Joint Swelling	☐Muscle Weakness
☐Joint Pain, Localized	☐Localized Joint Stiffness	☐Muscle Cramps
☐Gout Attack	☐Back Pain	☐Knee Pain
☐Varicose Veins	☐Other Pain: _____	

ENDOCRINE SYSTEM

☐Recent Weight Change	☐Tremors	☐Excessive Hunger
☐Temperature Intolerance	☐Excessive Thirst	☐Excessive Urination

Review of Systems – continued

EYES

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Watery Drainage
- ☐ Mucous-Like Drainage

EARS / NOSE / MOUTH / THROAT

- ☐ Ear Pain
- ☐ Trouble Hearing
- ☐ Ringing in Ears
- ☐ Ear Drainage
- ☐ Sneezing
- ☐ Clear Nasal Drainage
- ☐ Nasal Drainage/Mucous
- ☐ Nasal Stuffiness
- ☐ Nosebleeds
- ☐ Snoring
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Change in Voice
- ☐ Jaw Pain
- ☐ Facial/Sinus Pressure
- ☐ Tooth Ache
- ☐ Bleeding Gums
- ☐ Mouth Sores

BREAST

- ☐ Breast Lump
- ☐ Breast Pain (females)
- ☐ Nipple Discharge (females)

RESPIRATORY SYSTEM

- ☐ Cough
- ☐ Coughing up Blood
- ☐ Night Sweats
- ☐ Exposed to TB
- ☐ Shortness of Breath
- ☐ Trouble Sleeping Flat
- ☐ Coughing Up Sputum

CARDIOVASCULAR SYSTEM

- ☐ Palpitations
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Soft Tissue Swelling

GASTROINTESTINAL SYSTEM

- ☐ Appetite
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Belching
- ☐ Heartburn
- ☐ Flatulence (Gas)
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Stool Changes
- ☐ Bloody Stool
- ☐ Black Stool

GENITOURINARY SYSTEM

- ☐ Decreased Urine Volume
- ☐ Pain during Urination
- ☐ Blood in Urine
- ☐ Changes in Urinary Habits
- ☐ Urinary Loss of Control
- ☐ Birth Control Method: _____
- ☐ History of Venereal Disease
- ☐ Sexual Complaints

GENITOURINARY SYSTEM – *Females Only:*

- ☐ Vaginal Discharge
- ☐ Vulvar Itching/Burning
- ☐ Age at first period: _____
- ☐ Abnormal Menses Frequency
- ☐ Abnormal Menses Duration
- ☐ Heavy Bleeding
- ☐ Severe Menstrual Pain
- ☐ Vaginal Dryness
- ☐ Date of last Menstruation: _____
- ☐ Age at Menopause: _____
- ☐ Postmenopausal Bleeding

Summary of Previous Pregnancies:

- # Pregnancies: _____
- # Full-Term Deliveries: _____
- # Premature Deliveries: _____
- # Vaginal Deliveries: _____
- # C-Section Deliveries: _____
- # Living Children: _____
- # Miscarriages: _____
- # Elective Abortions: _____
- # Ectopic (Tubal) Pregnancies: _____

GENITOURINARY SYSTEM – *Males Only:*

- ☐ Testicle Symptoms
- ☐ Blood in Semen
- ☐ Abnormal Urethral Discharge
- ☐ Penile Lesion
- ☐ Decreased Urine Flow
- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Frequent Urination at Night

NEUROLOGICAL SYSTEM

- ☐ Sense of Smell Changes
- ☐ Taste Disturbances
- ☐ Difficulty Keeping Balance
- ☐ Difficulty in Speech
- ☐ Abnormality of Walk
- ☐ Increased Sensitivity to Touch / Pain
- ☐ Tingling
- ☐ Numbness
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Confusion
- ☐ Memory Loss
- ☐ Vertigo

PSYCHIATRIC HISTORY

- ☐ Interpersonal Relationship Problems
- ☐ Sleep Disturbances
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Lapses / Loss
- ☐ Hallucinations
- ☐ Thoughts of Hurting Yourself
- ☐ Thoughts of Hurting Someone Else
- ☐ Agitation
- ☐ Restless
- ☐ Sadness

Past Medical Hx

Do you have a **Medical History** of *(check all that apply)*:

☐ Allergic Rhinitis	☐ Chronic Bronchitis	☐ Glaucoma/Eye Disease	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Colitis	☐ Gout	☐ Peptic Ulcer
☐ Anemia	☐ Congestive Heart Failure	☐ Heart Attack	☐ Psychiatric Disorder
☐ Anxiety	☐ COPD	☐ Heartburn/GERD	☐ Renal / Kidney Disease
☐ Arthritis	☐ Crohn's Disease	☐ Heart Disease	☐ Seizure Disorder
☐ Asthma	☐ Dementia	☐ Hepatitis/Liver Disease	☐ Stroke Syndrome
☐ Birth Defects	☐ Depression	☐ High Cholesterol	☐ Substance Abuse
☐ Bleeding Disorder	☐ Diabetes Mellitus	☐ HIV Infection	☐ Thyroid Disorders
☐ Blood Clots	☐ Eczema	☐ Hypertension	☐ Tuberculosis
☐ Breast Lump	☐ Enlarged Prostate	☐ Lung Disease	☐ Other _____
☐ Cancer	☐ Genetic Disease	☐ Migraine Headaches	☐ Other _____

Surgery/Hospitalization

Please list any **Surgeries/Hospitalization** that you have had:

Surgery/Hospitalization/Injury	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Do you have a **FAMILY HISTORY** of *(check all that apply & indicate your relationship to the person affected)*:

☐ Allergic Rhinitis _____	☐ Crohn's Disease _____	☐ Hypertension _____
☐ Alzheimer's Disease _____	☐ Dementia _____	☐ Lung Disease _____
☐ Anemia _____	☐ Depression _____	☐ Migraine Headaches _____
☐ Anxiety _____	☐ Diabetes Mellitus _____	☐ Osteoporosis _____
☐ Arthritis _____	☐ Eczema _____	☐ Peptic Ulcer _____
☐ Asthma _____	☐ Enlarged Prostate _____	☐ Psychiatric Disorder _____
☐ Birth Defects _____	☐ Genetic Disease _____	☐ Renal/Kidney Disease _____
☐ Bleeding Disorder _____	☐ Glaucoma/Eye Disease _____	☐ Seizure Disorder _____
☐ Blood Clots _____	☐ Gout _____	☐ Stroke Syndrome _____
☐ Breast Lump _____	☐ Heart Attack _____	☐ Substance Abuse _____
☐ Cancer/Type:_____ _____	☐ Heart Disease _____	☐ Thyroid Disorders _____
☐ Chronic Bronchitis _____	☐ Heartburn/GERD _____	☐ Tuberculosis _____
☐ Colitis _____	☐ Hepatitis/Liver Disease _____	Other: _____ _____
☐ Congestive Heart Failure _____	☐ High Cholesterol _____	Other: _____ _____
☐ COPD _____	☐ HIV Infection _____	

Medications

Please list any **medications** that you are currently taking: Dose/Frequency

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

IMM

Last Tetanus shot: _____ Last Flu Vaccine: _____

Last Pneumonia Vaccine: _____ Last Chicken Pox Vaccine: _____

Last HPV Vaccine: _____ Last Shingles Vaccine: _____

Health Maintenance

Males: *(Indicate the approximate date of your last screening test _____)*

Age 35 and older: Cholesterol level _____

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening _____

Age 50 or older: Colon Cancer Screening _____

Last blood work: _____

Last prostate cancer screening: _____

Last stress test: _____

Last eye exam: _____

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) _____

Females: *(Indicate the approximate date of your last screening test _____)*

Age 40 and older: Mammogram _____

Age 21-65 or younger and sexually active for 3 years: Pap Test _____

Age 45 and older: Cholesterol level _____

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density _____

Age 50 or older: Colon Cancer Screening _____

Last blood work: _____

Last stress test: _____

Last eye exam: _____

Last dexa scan: _____

Age 25 and younger and sexually active: Chlamydia test _____

Other Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) _____