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.

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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
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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:	OR	☐ I authorize Lakeside Clinic, LLC to obtain information from:
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone # / Fax # (include area 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	☐ History & Physical	☐ Consult
☐ Laboratory test results	☐ X-ray reports	☐ Discharge Summary
☐ Office Notes	☐ DEXA Results	☐ 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

Adult Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)_____

Special Communication Needs:		
Language preference:		
	If 'yes' to any of the questions below, how can we assist?	
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	

Personal Health History

Please check past(P) or current(C) problems or conditions

P☐ C☐ Hypertension	P☐ C☐ Bowel/digestive problem
P☐ C☐ High cholesterol	P☐ C☐ Atrial Fibrillation
P☐ C☐ Diabetes	P☐ C☐ Seizures
P☐ C☐ Heart attack or angina	P☐ C☐ Headaches
P☐ C☐ Irregular heart rhythm	P☐ C☐ Stroke
P☐ C☐ Congestive heart failure	P☐ C☐ Prostate problem
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem
	P☐ C☐ Urinary tract infections
P☐ C☐ Pneumonia	P☐ C☐ Arthritis
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem
	P☐ C☐ Bleeding disorder
P☐ C☐ Asthma	P☐ C☐ Addiction Issues
P☐ C☐ Osteoporosis/Osteopenia	P☐ C☐ Depression
P☐ C☐ Cancer, Type:	P☐ C☐ Anxiety
P☐ C☐ Stomach ulcer	P☐ C☐ Mental Illness
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Other:
P☐ C☐ Liver Disease, Type:	

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Other: _____	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: **Concerns:** ☐ Stress ☐ Hazardous substances ☐ Heavy lifting

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

Describe:_____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _____
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages_____
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet ☐ Abdomen		Menopause ☐ Y ☐ N Age: _____

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: _____		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Cardiologist Name: _____ Phone: _____ Last Seen: _____	**Nephrologist** Name: _____ Phone: _____ Last Seen: _____
Ophthalmologist Name: _____ Phone: _____ Last Seen: _____	**Psychiatrist/Psychologist** Name: _____ Phone: _____ Last Seen: _____
Oncologist Name: _____ Phone: _____ Last Seen: _____	**Allergist** Name: _____ Phone: _____ Last Seen: _____
Urologist Name: _____ Phone: _____ Last Seen: _____	**Gynecologist** Name: _____ Phone: _____ Last Seen: _____
Gastroenterologist Name: _____ Phone: _____ Last Seen: _____	**Pulmonologist** Name: _____ Phone: _____ Last Seen: _____
Endocrinologist Name: _____ Phone: _____ Last Seen: _____	**Podiatrist:** _____ Name: _____ Phone: _____ Last Seen: _____
Other: _____ Name: _____ Phone: _____ Last Seen: _____	**Other:** _____ Name: _____ Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Last Occurrence
Tetanus vaccine / Tdap	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No	
Hepatitis ☐ A ☐ B	☐ Yes	☐ No	
Guardasil (HPV)	☐ Yes	☐ No	

Tests			Last Occurrence
Pap smear/pelvic	☐ Yes	☐ No	
Mammogram	☐ Yes	☐ No	
Bone Density	☐ Yes	☐ No	
Colonoscopy	☐ Yes	☐ No	
Prostate test	☐ Yes	☐ No	
Chest X-Ray	☐ Yes	☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ **Phone:** _____ **Store #:** _____

Location Description: _____