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
- ❑ 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

DOB:_____

Health History

Name: **Date:**

Circle any of the following conditions you have or have had in the past:

High blood pressure diabetes high cholesterol thyroid problem

Heart disease/blockages/heart attack cancer (what kind?_____)

Enlarged prostate asthma COPD/emphysema kidney disease

Arthritis Rheumatoid arthritis ulcers colon polyps

Osteoporosis/thin bones glaucoma stroke

Depression anxiety dementia liver disease/hepatitis

Congestive heart failure blood clots migraines

Abnormal pap smear seizures lupus

List any other conditions:

List all surgeries you have had:

List all allergies and type of reaction:

List all medications (including vitamins and over the counter meds):

Do you smoke? How many packs/day? When did you quit?

Do you drink alcohol? How much and how often?

Have you ever abused drugs, alcohol, or prescription drugs?

List the conditions your family members have/had:

Mother:

Father:

Sisters:

Brothers:

Children:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

When was your last:

Mammogram _____

Pap smear _____

Bone density _____

Prostate exam _____

Colonoscopy _____

Lab _____

Pneumonia shot _____

Tetanus shot _____Whopping Cough_____

Shingles shot _____

List the names of other doctors you see:

Circle any of the following you have had in the last month:

Fatigue weight loss weight gain frequent fever

Loss of appetite changes in vision Daily headaches

Chest pain shortness of breath fluttering of heart

Frequent swelling frequent dizziness passing out

Persistent heartburn persistent reflux difficulty swallowing

New diarrhea new constipation blood in stool blood in urine

Difficulty urinating problems with erection numbness/tingling

Confusion memory problems lumps in skin changes in moles

Persistent depression persistent anxiety frequent illnesses