Murfreesboro Family Care

David L. Johnson, M.D.

WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible care. To help us meet your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us. We will be happy to help.

DATE______________ ACCOUNT # (OFFICE USE ONLY)______________________________

PERSONAL INFORMATION

Full Name______________________________ Name called by____________________

Social Security #________________________

Date of Birth____________________ Sex M F

Street Address______________________________

City____________________ ST________ Zip____________________

Home PH____________________ Cell PH____________________

Employer____________________ Phone____________________

Spouse's Name____________________

Employer____________________Phone____________________

Where do you prefer to recieve calls? (check where you wish to be called)

______Home______Work______Mobile Day/Time______________

If you have an answering machine, may we leave the doctor's name? YES NO
In the event of an emergency please contact:

Name______________________________ Relationship______________________________

Home Phone____________________ Work Phone____________________

BILLING INFORMATION (Who will pay for services not covered by insurance?)

Name______________________________ Relationship to patient______________________________

Street Address______________________________ Date of Birth______________ SS#____________________

City____________________ State________ Zip Code______________

Work Phone____________________ Home Phone____________________

INSURANCE INFORMATION (please provide insurance card for us to copy)

Primary Ins co______________________________ Secondary Ins co______________________________

ID____________________ Group#______________ ID____________________ Group#______________

Insured's Name____________________ DOB__________ Insured's Name____________________ DOB__________

Insured's Rel to Patient SELF SPOUSE CHILD Insured's Rel to Patient SELF SPOUSE CHILD

Employer______________________________ Employer______________________________

Insured's SS#______________________________ Insured's SS#______________________________

FINANCIAL ARRANGEMENTS For your convenience, we offer the following methods of payment
Please circle the one you prefer

CASH PERSONAL CHECK CREDIT CARD(VISA/MASTERCARD)

Authorization and Release

I hearby authorize you to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during this period of such care to third party payers and/or other health practitioners. I authorize an request my insurance company to pay insurance benefits otherwise payable to me directly to the physician or physiscian group. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

Signature of patient or parent (if minor):______________________________ Date____________________

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

FAMILY MEDICINE
HEALTH QUESTIONNAIRE

Name: ______________________

✳ *Do you or have you had* ***persistent*** *problems with the following?* Date: ______________________

SKIN:
- Rashes ❑ Yes ❑ No
- Hair or Nails ❑ Yes ❑ No
- Do you have any tattoos? Y / N

HEAD:
- Headache ❑ Yes ❑ No
- Head Injury ❑ Yes ❑ No
- Blackouts ❑ Yes ❑ No
- Dizziness ❑ Yes ❑ No
- Memory Loss ❑ Yes ❑ No
- Depression ❑ Yes ❑ No
- Nervousness ❑ Yes ❑ No

EYES:
- Wear Glasses/Contacts ❑ Yes ❑ No
- Blurred Vision ❑ Yes ❑ No
- Cataracts ❑ Yes ❑ No
- Last Eye Exam: ______________________

NOSE/EARS:
- Allergies ❑ Yes ❑ No
- Sinus Trouble ❑ Yes ❑ No
- Hearing Loss ❑ Yes ❑ No
- Ringing ❑ Yes ❑ No

MOUTH:
- Dentures ❑ Yes ❑ No
- Hoarseness ❑ Yes ❑ No
- Gums ❑ Yes ❑ No
- Last Dental Exam: ______________________

NECK:
- Goiter/Thyroid ❑ Yes ❑ No
- Swollen "Glands" ❑ Yes ❑ No

EXTREMITIES:
- Joint Pain/Swelling ❑ Yes ❑ No
- Gout ❑ Yes ❑ No
- Numbness/Tingling ❑ Yes ❑ No
- Varicose Veins ❑ Yes ❑ No
- Phlebitis ❑ Yes ❑ No
- Back Trouble ❑ Yes ❑ No

LUNGS:
- Persistent Cough ❑ Yes ❑ No
- Cough Up Blood ❑ Yes ❑ No
- Emphysema/Bronchitis ❑ Yes ❑ No
- Pneumonia ❑ Yes ❑ No
- Last Chest X-Ray: ______________________

BREASTS:
- Nipple Discharge ❑ Yes ❑ No
- Lumps ❑ Yes ❑ No
- Do Self-Exam ❑ Yes ❑ No
- Last Mammogram: ______________________

HEART:
- Chest Pain w/Exercise ❑ Yes ❑ No
- Shortness of Breath ❑ Yes ❑ No
- Heart Murmur ❑ Yes ❑ No
- Sleep on more than 1 pillow ❑ Yes ❑ No
- Palpitations ❑ Yes ❑ No
- Swelling of Ankles ❑ Yes ❑ No
- Last EKG: ______________________

GASTROINTESTINAL:
- Trouble Swallowing ❑ Yes ❑ No
- Heartburn/Ulcer ❑ Yes ❑ No
- Vomiting ❑ Yes ❑ No
- Diarrhea ❑ Yes ❑ No
- Constipation ❑ Yes ❑ No
- Bloody/Black Stools ❑ Yes ❑ No
- Hemorrhoids ❑ Yes ❑ No
- Hepatitis ❑ Yes ❑ No

URINARY:
- Frequent Urination ❑ Yes ❑ No
- Trouble Starting ❑ Yes ❑ No
- Urinate During Night ❑ Yes ❑ No
- Leakage of Urine ❑ Yes ❑ No
- Blood in Urine ❑ Yes ❑ No
- Kidney Stones ❑ Yes ❑ No
- Infections ❑ Yes ❑ No

GENERAL:
- Blood Transfusion ❑ Yes ❑ No
- Rheumatic Fever ❑ Yes ❑ No
- Usual Weight ______________________
- Do you have a "living will"? Y / N

SEXUAL:
- Problems with Sex ❑ Yes ❑ No
- Multiple Partners ❑ Yes ❑ No
- History of VD ❑ Yes ❑ No
- (*Gonorrhea, Herpes, Syphilis, Warts, HIV*)

WOMEN:
- Painful Periods ❑ Yes ❑ No
- Irregular Periods ❑ Yes ❑ No
- On Birth Control Pills ❑ Yes ❑ No
- Form of Birth Control Used: ______________________
- Age Started Periods: ______________________
- Number of Pregnancies: ______________________
- Number of Children: ______________________
- Number of Miscarriages: ______________________
- Date of Last PAP Smear: ______________________
- Date Last Period Began: ______________________

Immunizations:

Date last Tetanus shot: ______________________

Date last Pneumonia shot: ______________________

Date last Flu shot: ______________________

Have had Hepatitis B series shots: Y / N