nashville weight loss SOLUTIONS

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NEW PATIENT DEMOGRAPHICS

Date: ______________________

Name: ____ Male______ Female______
Last Name *First* *MI*

Date of Birth: _____/_____/_____ Age: _____ SSN: ______- ______-______

Address: ____
Street (No P.O. Box) *City* *State* *Zip Code*

Hm Phone (___)______________ Wk Phone (___)_______________ Cell (___)_____________

Marital Status: __Married __ Single Cellular Carrier: _____________________________

Spouse Name _________________ Wk Phone (___)______________ Cell (___)_____________

Employment Status: ___Full ___Part Time ___Retired ___Unemployed ___Student

Employer Name: ___________________________________ Position: ______________________

Employer Address: ____
Street *City* *State* *Zip Code*

Emergency Contact/Relationship __________________ /__________ Cell (___)_____________

How did you learn about us? ____

I authorize you to leave a message on my home phone answering machine: Y N

I authorize you to e-mail at ____

I authorize you to contact me at my work number: Y N _____________________________
Signature

Primary Care Doctor

PCP's Name: ____

Address: ____

____

Office Phone #: (___) _______________ Fax #: (___) ________________

Preferred Pharmacy: ____

Pharmacy Phone #: (___) _________________

Primary Insurance Information

Name of Insurance Company: ____

Mailing address for claims: ____

____

Insured's ID/Policy/Subscriber #: ____

Insured's Group/Plan #: ______________________ Effective Date: _______________________

Name of Insured: ____

Relationship to Patient: ___________________________ Birthday: _______________________

Insured's Social Security #

____

Insured's Employer:___________________________________ Work Phone # _________________

Secondary Insurance Information

Name of Insurance Company: ____

Mailing address for claims: ____

____

Insured's ID/Policy/Subscriber #: ____

Insured's Group/Plan #: ______________________ Effective Date: _______________________

Name of Insured: ____

Relationship to Patient: ___________________________ Birthday: _______________________

Insured's Social Security #____

Insured's Employer:___________________________________ Work Phone # _________________

FINANCIAL POLICIES

Thank you for choosing *Nashville Weight Loss Solutions* as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Payments/Insurance

The patient is expected to present their current insurance card at each visit. All co-payments, deductibles, co-insurance and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. No post-dated checks will be accepted.

Insurance is a contract between you and your insurance company. In most cases, we are not a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we recommend that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any unpaid balance by your insurance company. In the event a claim is denied (predetermination is not a guarantee of payment), you are responsible for the full amount. If we are out of network for your insurance company, you may have a higher deductible, co-insurance, and/or out-of-pocket. In the event of delinquency, your account will be placed with a collection agency, and you will be liable for their additional charges.

Cancellations

We require 24 hours notice for cancelling follow-up appointments or new patient consults. If this policy is abused, then there will be a $50 fee charged to your account. There is a $500 fee charged to your account for cancelling your surgery or procedure within 48 hours of the scheduled date. In the event of delinquency, your account will be placed with a collection agency, and you will be liable for their additional charges.

AUTHORIZATION

I, ____,
(Please Print Name)

have fully read and understand the above statement of payment policy. I hereby authorize the release of pertinent medical information to my insurance carrier(s) and authorize my insurance benefits to be paid directly to Hugh L. Houston, M.D., realizing I am responsible for non-covered services.

I further authorize Dr. Houston to obtain or release my medical records to any physician regarding any physical condition or any treatment rendered to me, including diagnosis and prognosis that he deems necessary in the delivery and management of my medical care.

____ ____________________
Signature *Date*

PATIENT MEDICAL HISTORY

NAME ____ **AGE** _______________ **DATE** _______________________

Allergies: ____

Past Surgeries (list year and whether open or laparoscopic):____
____
____

Medical History: (check all that apply)

__Arthritis __Asthma __Blood Clots __Cancer __Depression __Diabetes __Heart Burn/Reflux __Heart Attack

__Heart Disease __High Blood Pressure __Sleep Apnea __Urinary Incontinence __High Cholesterol

Current Medications:____
____
____

Diet History:____
____

How long have you been more than 100 lbs. overweight? ______ years

Family Medical History (check all that apply):

__Blood Clots __Cancer __Diabetes __Heart Attack __High Blood Pressure __Obesity __Stroke

Social History:

Cigarette Use (circle): Y N ___ packs per day Alcohol Use (circle): daily weekly occasionally never

Review of Systems: (circle all that apply)

CARDIOVASCULAR: palpatations, pains in chest, pain in arm, pains in legs, shortness of breath at night,
Other: ____

GASTROINTESTINAL: heartburn, nausea, vomiting, belching fluid in throat, burning in throat, food sticking in chest, pains in stomach, burning in stomach, diarrhea, constipation, blood in stool,
Other: ____

GENITOURINARY: pain w/ urination, urine leakage w/ coughing/sneezing, problems w/ kidneys, frequent urination, urinary tract infection, bloody urine, other:____

MUSCULOSKELETAL: pain in joints, low back pain, knee pain, ankle/foot pain, sciatica, swelling in legs,
other: ____

RESPIRATORY: shortness of breath, shortness of breath with exercise, frequent upper respiratory infections, chronic cough,
other:____

PSYCHOLOGICAL: anxiety, depression, suicidal thoughts, suicidal attempts, psychiatric treatment, psychological counseling,
other:____

HEMATOLOGIC: Easy bruising, abnormal bleeding

OFFICE USE ONLY:

Height ________ Weight _________ BMI ________ BP _______/_______ Pulse ________