TENNESSEE LIMB AND BRACE

735 West Jackson ● Cookeville, TN 38501

CONFIDENTIAL PATIENT INFORMATION (Page 1 of 2)

NOT TO BE SHARED OR REPRODUCED WITHOUT ATTACHED SIGNED CONSENT

***Note to Patient: Please* PRINT *all responses except approval signature at end of page* 2**

_____

Patient's Last Name Patient's First Name Patient's Middle Name

_____ _____ _____ _____ _____ _____

Social Security # Date of Birth Male/Female Marital Status Height Weight

_____ _____ _____ _____

Home Address City State Zip Code

_____ _____ _____

Home Phone Work Phone Cell Phone

May we leave a message on your answering machine? **(Please Circle One):** Yes No

Comment: _____

Your Email Address if Available: _____

Emergency Contact Name/Phone Number: _____

Race (Please Circle One): American Indian/ Alaskan Native/ African American/ Native Hawaiian or Other Pacific Islander/ Asian/ White/Black/ Hispanic/ Latino/ Other/ Prefer Not to Answer

Education (Please circle highest level completed): Grade School/ High School/ GED/ Some College/ Tech Degree/ College Degree/ Graduate Degree/ Special Training (Please Explain):_____

_____/ Prefer Not to Answer

Are you ***now*** or ***past*** **(Please Circle One)** active in the Military (or as a First Responder: Fire/Police/Paramedic/ER)?

Years:_____ Branch:_____Rank/Title or Capacity:_____

Are you Diabetic? ____ If "Yes" Who treats you for your diabetes?_____

Who is your Referring Physician?_____Phone: _____

Who is your Primary Care Physician?_____Phone:_____

Have you ever received a power wheelchair?_____ If "yes," When? _____

Do you have a "Power of Attorney"? If "Yes" Please Provide Name and Phone Number here: _____

_____

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CONFIDENTIAL PATIENT CONSENT PAGE

FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS: (Page 2 of 2)

NOT TO BE SHARED OR REPRODUCED WITHOUT ATTACHED PATIENT INFORMATION PAGE 1 AND CONSENT SIGNATURE BELOW

Note to Patient: Please* PRINT *all responses except approval signature at end of form.

By signing this form, I consent to the use or disclosure of my protected health information by Tennessee Limb and Brace for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct Tennessee Limb and Brace healthcare operations.

I understand that I have the right to revoke this consent, in writing, at any time. My "protected health information" means any of my written and oral information, including demographic data that can be used to identify me as relates to my past, present, or future physical or mental health or condition.

I certify that I have received, or been offered, a copy of Tennessee Limb and Brace Notice of Privacy Practices. The Notice of Privacy Practices also describes my rights and Tennessee Limb and Brace duties with respect to my protected health information. _____Initial _____Date.

I request that payment of authorized benefits be made to either me or on my behalf to Tennessee Limb and Brace for services furnished to me by that physician or supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Health Care Financing Administration, or its agents, any information needed to determine these benefits payable for related services.

I understand that the information on this sheet will be used for billing purposes or for my health. I hereby assign payment directly to Tennessee Limb and Brace for expenses incurred and payable under the terms of my basic insurance, as well as major medical benefits for services rendered by Tennessee Limb and Brace. I understand that I am responsible to pay nay charges not covered by this assignment in full. I authorize any photocopies of this form to be valid. I understand if I receive insurance payments directly from my insurance company(s), I will immediately deliver those funds to Tennessee Limb and Brace upon receipt of payment for services rendered. In the event Tennessee Limb and Brace refers this account to any attorney or collection agency for collection, I agree to pay responsible attorney fees and all court costs and expenses incurred by Tennessee Limb and Brace in trying to collect any amount or difference owed by me, my heirs, or successors. This authorization of assignment applies to all occasions of services until revoked by the above-named person with a written statement thereof.

_____ Date: _____

Patient's Signature, or signature of guardian if patient is a minor

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CONFIDENTIAL PATIENT MEDICAL HISTORY (Page 3 of 4)

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Note: Please PRINT all responses **except approval signature at end of page 4**

YOUR NAME: _____ BIRTH DATE: _____TODAY'S DATE: _____

PLEASE CHECK BOXES BELOW FOR ALL CONDITIONS/ILLNESSESS YOU MAY NOW HAVE OR HAVE HAD IN THE PAST

☐ HEART PROBLEMS	☐ OSTEOPOROSIS	
☐ ALZHEIMERS (OR DEMENTIA)	☐ HEPATITIS	☐ PARKINSON'S
☐ ANXIETY	☐ HIGH BLOOD PRESSURE	☐ PULMONARY DISEASE
☐ ARTHRITIS	☐ HIV	☐ RHEUMATOID ARTHRITIS
☐ ASTHMA	☐ INFECTIONS	☐ SEIZURE DISORDER
☐ BRAIN INJURY (TBI)	☐ INTESTINAL PROBLEMS	☐ SKIN PROBLEMS
☐ CANCER	☐ KIDNEY DISEASE	☐ STOMACH PROBLEMS
☐ COPD	☐ LIVER DISEASE	☐ STROKE/TIA/CVA
☐ MIGRAINES	☐ VASCULAR DISEASE	☐ MRSA (STAPH)
☐ VISION PROBLEMS	☐ DIABETES TYPE 1	☐ NEUROLOGICAL PROBLEMS
☐ DIABETES TYPE 2	☐ OBESITY	☐ DEPRESSION
☐ HEARING LOSS	☐ OSTEOARTHRITIS	☐ OTHER_____

Have you had any falls in the last 6 months? _____ Number of times? _____ Help Required? _____
Have you had any hospital, Emergency Room, or Urgent Care visits in the last 6 months? _____ **Related to Falls?**_____

How would you describe Your General Health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent **. . . And your Activity Level?** ☐ Sedentary ☐ Limited ☐ Active ☐ Very Active

Are you here today because of (*Please circle which applies*): Employment-related accident? Vehicle-related accident? Military/First Responder-related accident? Other Accident? Condition since birth?

Have you received any type of medical/replacement or emergency device in the past 5 years? Yes _____ No_____
(If "YES" Please Describe): _____

Do you have any other known conditions other than listed above? Yes _____ No_____ Amputation? Please describe part(s) removed and date(s): _____
Name(s) of Surgeons: _____

Please list all allergies here: _____
Please list all ongoing medications here: _____

Patient's Signature and date this form is completed:_____

If completed by other than patient, please indicate relationship to patient:_____