Whitesburg Family Medicine

4800 Whitesport Circle, Suite 1. Huntsville, AL. 35801. 256.327.0888 Fax 256.327.0891
Sunitha A. Ghanta, M.D. Elisa J. Haley, MD David A. McMillion, MD

Patient Registration

Name: _____ Referred Here By: _____

Address: _____City:_____ State: _____ Zip: _____

Home Phone: _____Cell:_____ Gender: _____ DOB: _____

Email: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Age: _____ SSN: _____ Drivers Lic. #:_____ Marital Status: _____

Employer: _____ Occupation: _____ Work Phone: _____

Employer Address: _____ Date of Employment: _____

Spouses Name: _____ Spouses Employer_____

Spouses Occupation: _____ Spouses Work Phone: _____

Emergency Contact: _____Relation:_____ Phone: _____

PRIMARY INSURANCE INFORMATION

Name: _____

Group#_____ Contract#:_____ Co-pay_____

Name of Insured: _____ Relation to Patient: _____

Sex: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE INFORMATION

Name: _____

Group#_____ Contract#:_____ Co-pay_____

Name of Insured: _____ Relation to Patient: _____

Sex: _____ DOB: _____ SSN: _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Whitesburg Family Medicine to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to the party who accepts assignment. I certify that the information I have reported with regard to the patient's insurance coverage is correct.
I hereby acknowledge that I accept legal responsibility for all changes in connection with medical care provided by Whitesburg Family Medicine to myself, my minor child or as guardian of the above patient. I understand that my insurance company may not reimburse all of my charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State / Federal law. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency.

Signed_____ Date: _____

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Pediatric Patient Health History

Name: _____ Date of Birth: _____ Today's Date: _____
Last Doctor: _____ Reason For Leaving: _____
Other Doctors (Specialists):_____
Child's Dentist and last visit: _____
Current Symptoms: _____
_____
Drug or Food Allergies (What happens to your child?):_____

Past Medical History (Check or Write In)

Allergies (Seasonal)	☐	**Diabetes**	☐	**Seizure Disorder**	☐
Anemia	☐	**Ear Infections**	☐	**Stroke**	☐
Asthma	☐	**Fractures**	☐	**Thyroid Disease**	☐
Birth Defect	☐	**GERD (Reflux)**	☐	**Ulcerative Colitis**	☐
Bleeding Disorder	☐	**Heart Disease**	☐	**Urinary Tract Infections**	☐
Blood Clots	☐	**High Blood Pressure**	☐	**Venereal Disease (STD)**	☐
Breast Lump	☐	**High Cholesterol**	☐	**Other**	☐
Bronchiolitis (RSV)	☐	**HIV**	☐	**_____**	
Cancer	☐	**Liver Disease**	☐	**_____**	
Crohn's Disease	☐	**Migraines**	☐	**_____**	
Depression	☐	**Psychiatric Disease**	☐		

Surgeries

Surgery	Date / Location	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History

Is this your child by birth? ☐ Adoption? ☐ Stepchild? ☐ Other? ☐_____

Birth Weight: _____ APGAR's (if known): _____ Method of delivery: _____

Born at _____ weeks of pregnancy? Were there any complications with pregnancy or delivery?
_____
_____
_____
_____

Medications

Name / Dose		

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Pediatric Patient Health History (Continued)

Name: _____ Today's Date: _____

Development

At what age did your child: Sit alone____ Walk alone____ Start talking____ Toilet Train____

Current School: _____ Current grade: _____

First menstrual period (girls): _____

Nutrition

Was (is) your child breastfed(ing)? ____ If so for how long? _____

Has you child had any feeding problems? _____

How many ounces of milk per day? _____ How many ounces of juice per day? _____

Please describe your child's diet:

_____

_____

Family History

In each box please write age of disease onset	Arthritis	Anxiety	Bleeding Disorder	Cancer (Type)	Colitis	Dementia	Eye Disease	Gout	Heart Attack	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Liver Disease	Migraines	Osteoporosis	Psychiatric Disease	Seizures	Stroke	Thyroid Disease
Mother																				
Father																				
Sister																				
Brother																				
Grandmother																				
Grandfather																				

Habits / Exposure

Who in the household smokes? _____

Any exposure to lead? (old house, peeling paint, etc)_____

How many hours of TV per day? _____ Computer? _____ Video games? _____

Does your child play any sports, and if so which sports?

_____

What does your child do for fun other than sports?

_____

_____

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Pediatric Patient Health History (Continued)

Name: _____ **Today's Date: _____**

Symptoms (in the last 6 months)

General

Fever ☐
Chills ☐
Fatigue ☐
Weight loss ☐
Skin changes ☐

EENT

Hearing changes ☐
Vision changes ☐
Double vision ☐
Ringing in ears ☐
Dizziness ☐
Eye pain ☐
Ear pain ☐
Nose bleeds ☐
Hoarseness ☐

Cardiovascular

Chest pain ☐
Chest tightness ☐
Irregular beat ☐
Rapid heartbeat ☐
Ankle swelling ☐
Varicose veins ☐
Exercise intolerance ☐

Pulmonary

Persistent cough ☐
Wheeze ☐
Blood in sputum ☐
Short of breath ☐
Painful breathing ☐
TB exposure ☐

Gastrointestinal

Poor appetite ☐
Swallowing problems ☐
Heartburn ☐
Vomiting ☐
Constipation ☐
Diarrhea ☐
Gas ☐
Bloating ☐
Excessive thirst ☐
Hemorrhoids ☐
Nausea ☐
Stomach pain ☐
Blood in stools ☐
Blood in vomit ☐
Change in stools ☐
Tarry stools ☐

Musculoskeletal

Joint pain ☐
Joint swelling ☐
Joint stiffness ☐
Joint deformity ☐
Muscle pain ☐
Weakness ☐
Muscle cramps ☐

Neurological

Weakness on one side ☐
Headache ☐
Fainting ☐
Seizures ☐
Loss of balance ☐
Tremor ☐

Genitourinary

Painful urination ☐
Blood in urine ☐
Can't hold urine ☐
Can't urinate ☐
Weak stream ☐
Going too often ☐
Increased night time urination ☐
Discharge: Penile / Vaginal ☐

Psychiatric

Change in mood ☐
Loss of pleasure ☐
Can't sleep ☐
Too much energy ☐

Health Maintenance / Immunizations

(Please check all that apply and bring immunization record to first appointment)

Hepatitis B (3)	☐	☐	☐		
DTaP (5)	☐	☐	☐	☐	☐
Hib (4)	☐	☐	☐	☐	
Prevnar (4)	☐	☐	☐	☐	
Rotavirus (3)	☐	☐	☐		
Polio (IPV) (4)	☐	☐	☐	☐	
MMR (2)	☐	☐			
Varicella (2)	☐	☐		Had Chicken Pox ☐	
Hepatitis A (2)	☐	☐			
Meningococcal (1)	☐				
Gardasil (3) (females)	☐	☐	☐		

Reviewed By: _____ **Date: _____**

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Receipt of Privacy Practices; Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____, was provided a copy of Whitesburg Family Medicine's Privacy Practices Notification. Whitesburg Family Medicine may revise it's notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Whitesburg Family Medicine to use or disclose my PHI in conjunction with Whitesburg Family Medicine's treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature of Patient / Guardian **Date**

Further I hereby authorize and give my consent to Whitesburg Family Medicine to leave messages on my answering machine / voicemail for the following (check all that apply)

Appointment Reminders	_____	**Prescription Refills**	_____
Medical Information	_____	**Test Results**	_____
Insurance / Payment Issues	_____	**Mail**	_____

I further authorize and give consent to Whitesburg Family Medicine to communicate any of my PHI to the following person / persons:

Name	Relationship	Phone Number

_____ _____
Signature of Patient / Guardian **Date**

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Authorization for Release / Request of Protected Health Information

Patient's Name: _____ DOB: _____
Address: _____
City: _____ State: _____ ZIP: _____
Email: _____
SSN#:_____ Patient's Phone #:_____
Date of Request: _____ Date Information Needed: _____

☐ **I Authorize**	☐ **David A. McMillion**
	☐ **Elisa J. Haley**
	☐ **Sunitha A. Ghanta**

To RELEASE information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, ZIP

_____
Phone and Fax #

OR

☐ **I Authorize**	☐ **David A. McMillion**
	☐ **Elisa J. Haley**
	☐ **Sunitha A. Ghanta**

To RECEIVE information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, ZIP

_____
Phone and Fax #

Reason for this request:

☐ **Healthcare** ☐ **Insurance** ☐ **Personal** ☐ **Other**

Type of Records Requested:

☐ **Consult** ☐ **Lab Results** ☐ **Imaging Results**
☐ **Discharge Summary** ☐ **Office Notes** ☐ **Other**
☐ **History and Physical** ☐ **Operative Report**

☐ **Medical Records Related to a Specific Illness or Injury and Date_____**

☐ **All Medical Records**

- **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 healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.**
- **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 requested records.**

_____ _____
Signature of Patient or Guardian **Date**