CUMBERLAND FAMILY PRACTICE

264 NEW SHACKLE ISLAND RD, STE. #107
HENDERSONVILLE, TN 37075
PHONE: 615-824-4244 FAX: 615-824-5916

PLEASE COMPLETE IN **PEN**, NOT PENCIL.

PATIENT DEMOGRAPHICS

NAME: ____
FIRST MIDDLE LAST

DATE OF BIRTH: ______________ SOCIAL SECURITY #: ____-____-____ MALE FEMALE

STREET ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: ____________

PRIMARY PHONE: ______________________ HOME MOBILE WORK SPOUSE CAREGIVER

SECONDARY PHONE: ______________________ HOME MOBILE WORK SPOUSE CAREGIVER

E-MAIL ADDRESS: ____

PHARMACY: ______________________________

PRIMARY INSURANCE

NAME: ______________________

SUBSCRIBER ID: ______________________

GROUP ID: ______________________

SECONDARY INSURANCE (IF APPLICABLE)

NAME: ______________________

SUBSCRIBER ID: ______________________

GROUP ID: ______________________

EMERGENCY CONTACT #1: ______________________________

RELATION: ______________________ PHONE: ______________________

EMERGENCY CONTACT #2 (OPTIONAL): ______________________________

RELATION: ______________________ PHONE: ______________________

MARITAL STATUS: O SINGLE O MARRIED O DIVORCED O WIDOWED O OTHER: ____________

EMPLOYER: ______________________ HOW LONG AT CURRENT EMPLOYER: ____________

RACE: ______________________

ETHNICITY: ______________________

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1. ______________________ 5. ______________________

2. ______________________ 6. ______________________

3. ______________________ 7. ______________________

4. ______________________ 8. ______________________

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

NAME	STRENGTH	DIRECTION	PRESCRIBED BY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

COVID19 VACCINE YEAR:	BONE DENSITY SCAN YEAR:	COLONOSCOPY YEAR:
COVID19 BOOSTER (1) YEAR:	MAMMOGRAM YEAR:	PROSTATE EXAM YEAR:
COVID19 BOOSTER (2) YEAR:	ECHOCARDIOGRAM YEAR:	RECTAL EXAM YEAR:
PNEUMONIA VACCINE YEAR:	PAP SMEAR YEAR:	PELVIC EXAM YEAR:
SHINGLES VACCINE YEAR:	GLUCOSE READING YEAR:	HEARING EXAM YEAR:
HEPATITIS B SHOT YEAR:	HEMOCCULT TEST YEAR:	GLAUCOMA/EYE EXAM YEAR:
FLU VACCINE YEAR:	PSA TEST YEAR:	NUTRITIONAL THERAPY YEAR:
TETANUS DIPHTHERIA YEAR:	LIPID PANEL YEAR:	SMOKING CESSATION YEAR:
ABDOMINAL ANEURYSM SCREENING YEAR:	DIABETES SELF-MANAGEMENT TRAINING YEAR:	

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. ______ YEAR: ______
2. ______ YEAR: ______
3. ______ YEAR: ______
4. ______ YEAR: ______
5. ______ YEAR: ______
6. ______ YEAR: ______

LIST ANY CHILDHOOD ILLNESSES

1. ______
2. ______
3. ______
4. ______

LIST HEALTH PROBLEMS AND CAUSES OF DEATH, IF APPLICABLE

			AGE	MEDICAL PROBLEMS
FATHER	O LIVING	O DECEASED		
MOTHER	O LIVING	O DECEASED		
BROTHER(S)	O LIVING	O DECEASED		
	O LIVING	O DECEASED		
	O LIVING	O DECEASED		
SISTER(S)	O LIVING	O DECEASED		
	O LIVING	O DECEASED		
	O LIVING	O DECEASED		
FATHER'S FATHER	O LIVING	O DECEASED		
FATHER'S MOTHER	O LIVING	O DECEASED		
MOTHER'S FATHER	O LIVING	O DECEASED		
MOTHER'S MOTHER	O LIVING	O DECEASED		

SOCIAL HISTORY

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):			
1.		5.	
2.		6.	
3.		7.	
4.		8.	

EDUCATION: O HIGH SCHOOL O COLLEGE O SOME COLLEGE O TRADE SCHOOL O OTHER:____________________________

DIET: O BALANCED O VEGETARIAN O DIABETIC O LOW SALT O LOW FAT O LOW CARB O OTHER: ________________

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? O YES O NO IF YES, HOW MANY HOURS?_________________

HAVE YOU EVER VAPED, SMOKED, OR CHEWED TOBACCO? O YES O NO IF YES, HOW MUCH?________________________

DO YOU DRINK ALCOHOL? O YES O NO O SOCIALLY IF YES, HOW MUCH?__________________________

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? O YES O NO

PLEASE INDICATE IF YOU DO OR DO NOT NEED HELP PERFORMING THESE ROUTINE TASKS

FEEDING YOURSELF	o YES o NO IF YES, WHO HELPS?___________________________
GETTING FROM BED TO CHAIR	o YES o NO IF YES, WHO HELPS?___________________________
GETTING TO THE TOILET	o YES o NO IF YES, WHO HELPS?___________________________
GETTING DRESSED	o YES o NO IF YES, WHO HELPS?___________________________
BATHING OR SHOWERING	o YES o NO IF YES, WHO HELPS?___________________________
USING THE TELEPHONE	o YES o NO IF YES, WHO HELPS?___________________________
TAKING YOUR MEDICINES	o YES o NO IF YES, WHO HELPS?___________________________
PREPARING MEALS	o YES o NO IF YES, WHO HELPS?___________________________
SHOPPING FOR GROCERIES	o YES o NO IF YES, WHO HELPS?___________________________
DRIVING	o YES o NO IF YES, WHO HELPS?___________________________
CLIMBING A FLIGHT OF STAIRS	o YES o NO IF YES, WHO HELPS?___________________________
MANAGING MONEY (TRACKING EXPENSES/PAYING BILLS)	o YES o NO IF YES, WHO HELPS?___________________________
WALKING ACROSS THE ROOM (WITH A CANE/WALKER)	o YES o NO IF YES, WHO HELPS?___________________________
MODERATELY STRENUOUS HOUSEWORK (LAUNDRY)	o YES o NO IF YES, WHO HELPS?___________________________
SHOPPING FOR PERSONAL ITEMS (TOILETRIES/MEDICINES)	o YES o NO IF YES, WHO HELPS?___________________________

CHECK YES, NO, OR SOMETIMES FOR EACH QUESTION

Question			
DO YOU FIND IT DIFFICULT TO FOLLOW A CONVERSATION IN A CROWDED ROOM?	○ YES	○ NO	○ SOMETIMES
DO YOU FEEL THAT PEOPLE ARE MUMBLING OR NOT SPEAKING CLEARLY?	○ YES	○ NO	○ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY FOLLOWING DIALOGUE IN A THEATER?	○ YES	○ NO	○ SOMETIMES
DO YOU FIND YOURSELF ASKING PEOPLE TO SPEAK UP OR REPEAT THEMSELVES?	○ YES	○ NO	○ SOMETIMES
DO YOU FIND MEN'S VOICES EASIER TO UNDERSTAND THAN WOMEN'S?	○ YES	○ NO	○ SOMETIMES
DO YOU EXPERIENCE DIFFICULTY UNDERSTANDING SOFT/WHISPERED SPEECH?	○ YES	○ NO	○ SOMETIMES
DO YOU FEEL HANDICAPPED BY A HEARING PROBLEM?	○ YES	○ NO	○ SOMETIMES
DO YOU EXPERIENCE RINGING/NOISES IN YOUR EARS?	○ YES	○ NO	○ SOMETIMES
DO YOU HEAR BETTER WITH ONE EAR THAN THE OTHER?	○ YES	○ NO	○ SOMETIMES
HAVE ANY OF YOUR RELATIVES (BY BIRTH) HAD HEARING LOSS?	○ YES	○ NO	○ SOMETIMES
DO YOU HAVE DIFFICULTY UNDERSTANDING SPEECH ON THE TELEPHONE?	○ YES	○ NO	○ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO FEEL EMBARASSED MEETING PEOPLE?	○ YES	○ NO	○ SOMETIMES
DO YOU FIND IT DIFFICULT TO UNDERSTAND A SPEAKER AT A PUBLIC MEETING/EVENT?	○ YES	○ NO	○ SOMETIMES
DOES A HEARING PROBLEM CAUSE YOU TO VISIT FRIENDS/FAMILY LESS OFTEN THAN YOU WOULD LIKE?	○ YES	○ NO	○ SOMETIMES
HAVE YOU HAD ANY SIGNIFICANT NOISE EXPOSURE DURING WORK, RECREATION, OR MILITARY SERVICE?	○ YES	○ NO	○ SOMETIMES
DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS?	○ YES	○ NO	○ SOMETIMES
DO YOU FEEL DOWN, DEPRESSED OR HOPELESS?	○ YES	○ NO	○ SOMETIMES
ARE YOU AFRAID OF FALLING?	○ YES	○ NO	○ SOMETIMES
HAVE YOU FALLEN IN THE PAST YEAR?	○ YES	○ NO	○ SOMETIMES

PLEASE NOTE ANY ADDITIONAL CONCERNS YOU WISH TO SPEAK WITH YOUR PROVIDER ABOUT:

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ○ YES ○ NO

DO YOU HAVE A POWER OF ATTORNEY? ○ YES ○ NO

____ ____________________

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE

CUMBERLAND FAMILY PRACTICE
264 NEW SHACKLE ISLAND RD STE #107 HENDERSONVILLE, TN 37075
PHONE: 615-824-4244
FAX: 615-824-5916

Patient HIPAA consent for physician to use or disclose health care information for treatment, payment, and health care operations.

Patient's Name:____

Date of Birth:____________________ **Social Security Number:**______________________________

To give consent to disclose health care information to someone other than the patient, please write their name below: (e.g. spouse, parent, caretaker, family member, etc.)

Name:____

I understand that my health information is private and confidential. I understand that **Cumberland Family Practice** works very hard to protect my privacy and confidentiality of my personal health information.

I understand that signing this document means that **Cumberland Family Practice** may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health operations. Failure to sign this consent may results in the physician declining to treat me.

Under the terms of this consent, I can ask **Cumberland Family Practice** to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that **Cumberland Family Practice** does not have to agree to my request. If they do agree, I understand that they will follow the agreed upon limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel this consent, I understand that **Cumberland Family Practice** may have already used and disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent by doing one of the following: Writing, signing, and dating a letter to **Cumberland Family Practice** that says I want to revoke my consent authorizing the use of my personal health information.

I understand that if I cancel this consent, **Cumberland Family Practice** is not obligated to provide further health care services to me.

My signature below indicates that I agree to the policies outlined by the documents and all statements therein.

____ ________________
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

____
RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)

PATIENT PORTAL INFORMED CONSENT

Patient Information:

Name: ____
First MI Last

DOB: ___________________________ E-Mail Address: ______________________________________

PURPOSE OF THIS FORM

Cumberland Family Practice offers secure viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that; you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

HOW THE SECURE PATIENT PORTAL WORKS

A secure Web portal is a kind of webpage that uses encryption to keep unauthorized person from reading communications, information, or attachments. Secure messages and information can only be ready by someone who knows the right password to log into the portal site.

HOW TO PARTICIPATE IN OUR PATIENT PORTAL

You can pickup secure message or view information sent to you through a website. Once this form is agreed to and signed, we will send you an e-mail notification that tells you how to register for the first time. This notification will give you the URL (Internet address) of the website where you can log in using the username and password provided. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can view more clinic specific information or access the Patient Portal through our clinic web page: www.cumberlandfamily practice.com

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS

This encrypted method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including e-mail addresses.

CONDITIONS OF PARTICIPATING IN THE PATIENT PORTAL

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold Cumberland Family Practice or any of its staff liable for network infractions beyond their control.

Patient Acknowledgement: ____________________________________Date: ________________________

Office Use: USER NAME: ____

Temporary Password: cumberland

CUMBERLAND FAMILY PRACTICE

264 NEW SHACKLE ISLAND ROAD

SUITE 107

HENDERSONVILLE, TN 37075

615-824-4244   PHONE

615-824-5916   FAX

Dr. Raul Couret, Jr., Dr. Steven Faulks, Dr. David Montgomery, Dr. Guru Medam

Patient Name: ____

Address: ____

Date of Birth: __________________________ SS #: _______________________________

Cumberland Family Practice is authorized to **FURNISH TO or RECEIVE FROM** (Circle Choice):

Facility Doctor Name: ____

Address: ____

Phone: _______________________________ Fax: _________________________________

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS

_______ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communication to social workers and/or psychotherapies, psychologist, if any.

_______ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS specifically described below:

____

____

I release Cumberland Family Practice, Dr. Raul Couret, Jr., Dr. Steven Faulks, Dr. David Montgomery, Dr. Guru Medam and the recipient/discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

____   ________________________________

Patient Signature (Parent’s Representative if Minor)   Date

LIST ANY PHYSICIANS AND/OR PRACTITIONERS YOU CURRENTLY SEE

NAME: ______________________________

SPECIALTY: ____________________ CITY/STATE: ____________________

NAME: ______________________________

SPECIALTY: ____________________ CITY/STATE: ____________________

NAME: ______________________________

SPECIALTY: ____________________ CITY/STATE: ____________________

NAME: ______________________________

SPECIALTY: ____________________ CITY/STATE: ____________________

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