

**Family Practice Associates of Southern Hills**  
 397 Wallace Rd., Bldg. C • Suite 100 • Nashville, TN 37211  
 Phone: (615) 834-6166

**REGISTRATION INFORMATION**

Date: \_\_\_\_\_ Physician: \_\_\_\_\_

|  |   |  |                          |
|--|---|--|--------------------------|
| <b>Patient's Legal Name:</b>   |   |  |                          |
| Last:  | First:                                    | Middle:<br>Initial:  | Female:<br>Male:         |
| <b>Permanent Address:</b> (Please do not use a PO Box number)            |   | Is this visit due to an accident:                              |                          |
| Street:  | Work Comp                                 | Auto   | Other                    |
| City:  | State:                                    | Zip:   |                          |
| Home Phone (Include Area Code):<br>( )                                   | Female:<br>Male:                          | Marital Status:(circle one)<br>Single Married Divorced Widowed |                          |
| Date of Birth:<br>/ /  | Referred By:                              | Social Security Number:  |                          |
| Employers Name:  | Occupation:                               | Employers Phone:<br>( )  |                          |
| Employers Address:   | City:                                     | State:   | Zip:                     |
| Emergency Notification:(Person not living with you):                     | Home Phone (Include Area Code):<br>( )    |  |                          |
| Address:<br>City:  | State:                                    | Zip:   | Relationship to Patient: |
| <b>Responsible party for payment (if under 18 years of age):</b>         |   | Relationship to Patient:                                       |                          |
| Address of Responsible Party (if different from patient):                |   |  |                          |
| Street:  | City:                                     | State:   | Zip:                     |
| Spouse's Name:   | Social Security Number:                   | Date of Birth:<br>/ /  |                          |
| Spouse's Employer:   | Occupation:                               |  |                          |
| Spouse's Employers Address:  | Business Phone:(Include Area Code)<br>( ) |  |                          |
| Street:  | City:                                     | State:   | Zip:                     |
| <b>Who's Insurance is this?<br/>Please fill this out on that person:</b> |   |  |                          |
| <b>Primary Insurance Company Name:</b>                                   |   | Is Medicare your Primary Insurance?<br>Yes No                  |                          |
| Name:  | Date of Birth:<br>/ /                     |  |                          |
| Insured's Policy or ID Number:   | Group Number:                             |  |                          |
| Primary Insurance Company Address:                                       |   |  |                          |
| Street:  | City:                                     | State:   | Zip:                     |
| <b>Secondary Insurance Company Address:</b>                              |   | Name:  |                          |
| Insured's Policy or ID Number:   | Group Number:                             | Date of Birth:<br>/ /  |                          |
| Secondary Insurance Company Address:                                     |   | Do You Have A Living Will?<br>Yes No                           |                          |
| Street:  | City:                                     | State:   | Zip:                     |



**ALLERGIES**

Please list any drug allergies and the type of reaction you experience with each drug.

| Drug | Reaction |
|------|----------|
|      |          |
|      |          |
|      |          |

**REVIEW OF SYMPTOMS**

Please check any of the following symptoms that apply to you.

| Past                     | Present                  | Symptom                            | Past                     | Present                  | Symptom                               |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Weight change (unexpected)         | <input type="checkbox"/> | <input type="checkbox"/> | Trouble swallowing                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever                              | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills                             | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                            | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                          | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats                       | <input type="checkbox"/> | <input type="checkbox"/> | Black, tarry stool                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble sleeping                   | <input type="checkbox"/> | <input type="checkbox"/> | Pencil-thin stool                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Appetite change                    | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache                           | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual change                      | <input type="checkbox"/> | <input type="checkbox"/> | Nausea / Vomiting                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss                       | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting of blood                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache                            | <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain which:                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge                      | <input type="checkbox"/> | <input type="checkbox"/> | Occurs after a meal                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears                    | <input type="checkbox"/> | <input type="checkbox"/> | Occurs with eating greasy, fried food |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds                         | <input type="checkbox"/> | <input type="checkbox"/> | Awakens you at night                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems                     | <input type="checkbox"/> | <input type="checkbox"/> | Is relieved by antacids               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums                      | <input type="checkbox"/> | <input type="checkbox"/> | Seasonal / environmental allergies    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness                         | <input type="checkbox"/> | <input type="checkbox"/> | Red, itchy eyes                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat                        | <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath:               | <input type="checkbox"/> | <input type="checkbox"/> | Rash                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | When doing usual work              | <input type="checkbox"/> | <input type="checkbox"/> | Change in moles                       |
| <input type="checkbox"/> | <input type="checkbox"/> | When climbing one flight of stairs | <input type="checkbox"/> | <input type="checkbox"/> | Itchy skin                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Which awakens you at night         | <input type="checkbox"/> | <input type="checkbox"/> | Burning when urinating                |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                              | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood                  | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                           | <input type="checkbox"/> | <input type="checkbox"/> | Trouble starting urination            |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain or tightness:           | <input type="checkbox"/> | <input type="checkbox"/> | Trouble holding urine                 |
| <input type="checkbox"/> | <input type="checkbox"/> | When walking fast or up a hill     | <input type="checkbox"/> | <input type="checkbox"/> | Frequent nighttime urination          |
| <input type="checkbox"/> | <input type="checkbox"/> | After a heavy meal                 | <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain                           |
| <input type="checkbox"/> | <input type="checkbox"/> | When upset or exited               | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain                            |
| <input type="checkbox"/> | <input type="checkbox"/> | That radiates down your arm        | <input type="checkbox"/> | <input type="checkbox"/> | Numbness                              |
| <input type="checkbox"/> | <input type="checkbox"/> | That disappears when you rest      | <input type="checkbox"/> | <input type="checkbox"/> | Weakness                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat                | <input type="checkbox"/> | <input type="checkbox"/> | Seizures                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles                 | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                            |                          |                          |                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                         |                          |                          |                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Stress                             |                          |                          |                                       |

**IMMUNIZATIONS**

Date of last tetanus booster: \_\_\_\_\_

Date of last pneumonia vaccine: \_\_\_\_\_



**MEN ONLY**

Please check any of the following symptoms that apply to you.

| Past                     | Present                  | Conditions              | Past                     | Present                  | Conditions                   |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sexual function | <input type="checkbox"/> | <input type="checkbox"/> | Prostate trouble             |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from penis    | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump in testicles       | <input type="checkbox"/> | <input type="checkbox"/> | Surgery on private parts     |

If you are sexually active, do you use condoms?      Yes      No

**WOMEN ONLY**

Please check any of the following symptoms that apply to you.

| Past                     | Present                  | Conditions                   | Past                     | Present                  | Conditions          |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding between periods     | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Pap smear  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy periods                | <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge    |
| <input type="checkbox"/> | <input type="checkbox"/> | Extreme menstrual pain       | <input type="checkbox"/> | <input type="checkbox"/> | Breast lump         |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual vaginal discharge    | <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes         |

| Menstrual History                     | Obstetric History                           |
|---------------------------------------|---|
| Date of last menstrual period: _____  | Number of times you've been pregnant: _____ |
| Age at first period: _____            | Number of children born alive: _____        |
| Length of periods: _____              | Number of children born dead: _____         |
| Number of days between periods: _____ | Number of miscarriages: _____               |
| Age when periods stopped: _____       | Number of Caesarean sections: _____         |
|                                       | Complications of pregnancy: _____           |
| Date of last Pap smear: _____         | Date of last mammogram: _____               |
| Was it normal?      Yes      No       | Was it normal?      Yes      No             |

If you are sexually active, do you use birth control?      Yes      No      If yes, what type? \_\_\_\_\_

HCA Physician Services  
Family Practice Associates of Southern Hills  
**Patient Consent Form**

*(Please Read and Sign)*

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I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Family Practice Associates of Southern Hills may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Family Practice Associates of Southern Hills will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Family Practice Associates of Southern Hills.

I acknowledge that I have been given the Family Practice Associates of Southern Hills Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**