New Patient Information

Thomas St. Medical Clinic
65 S. Thomas
Tupelo, MS 38801
Phone: 662-205-4475
Fax: 662-205-4737

Patient Full Name:____

Age:____ DOB:____ Sex M / F

SSN:_____________________ Marital Status M S D W Separated________________________

Home Address:________________________________ City___________ ST_____ Zip_______

Home Phone:__________________ Work Phone:_______________ Cell Phone:_____________

Employer:_____________________________________ Address:________________________

Email Address:_____________________________________

Primary Care Doctor's Name:__________________________ Phone Number:___________

Patients Spouse:_________________ Employer:_________________ Work #:______________

Emergency Contact:________________ Ph #:____________________ Relationship__________

Who is responsible for payment, If not Patient?____

Name:_______________________________ Phone Number:____________________________

Address:____________________________ City:__________________ St_____ Zip_________

Relationship to Patient:___________________________________

Primary Insurance:____________________ Policy #_______________ Group #_____________

Subscriber Name:_____________________ SSN#:__________________ DOB___/___/___

Secondary Insurance:____________________ Policy #_______________ Group #___________

Subscriber Name:_____________________ SSN#:__________________ DOB___/___/___

I hereby authorize Thomas St. Medical Clinic to release any information concerning my illness/accident and treatment to Insurance Carriers. I hereby assign Thomas St. Medical Clinic all payments for medical services rendered to my dependents or myself. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient or Guardian:_____________________________________ Date:____________________

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Authorization For Use or Disclosure of Health Information

Patient Name:________________________________ DOB:_________________ SSN#______________

Address:____

I authorize_____________________________________ to disclose the information from my record to the Thomas St. Medical Clinic.

I authorize the disclosure of:	The purpose of disclosure
__ Verbal/Written Treatment Progress Notes	__ Continuity of Care
__ Medications	__ Determine Eligibility for Disability
__ Progress Notes	__ For Health/Life Insurance
__ Lab Results	__ Legal
__ X-Rays	__ My Personal Records
__ Psychiatric/Psychological Evaluations	__ Other

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date in event or condition: _________________. If I fail to specify an expiration date, event or condition, this authorization will automatically expire in (6) months.

I understand that I can refuse to sign this authorization, I need not sign this form to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may then be no longer protected by Federal Confidentiality Rules.

Signature of Patient or Representative   Print Name of Patient Representative

Date:__________________________ Relationship to Patient___________________________________

Medical History

Patient Name: ___________________________________ DOB __/__/__ Date:_____________

Past Surgical History

	Name of Operation	Date	Physician	Reason	Hospital
1					
2					
3					
4					
5					
6					

Have you or a family member had any problems with Anesthesia? __ Yes __ No

If yes, Explain:____

Have you or a family member had any problems with Bleeding? __Yes __ No

If yes, Explain:____

Do you have a sensitivity or allergy to Latex? __Yes __No If yes, Explain:_________________________

Past Medical Illness (Check all that apply)

__Diabetes __Ulcers __Congestive Heart Failure __Thyroid(treatement Date:_____)
__Angina __Asthma __Kidney Disease __Stroke(date______)
__Arthritis __Depression __High Cholesterol/Lipids __Heart Attack(date_____)
__Anxiety __Gastric Reflux __Lung Disease __Hepatitis/Jaundice(date_____)
__None __Heart Disease __Blood Transfusion/Reaction
__Cancer (date, type & treatment_________) __ Others____

Drug Allergies __None Known

	Name of Medications	What happens when you take this drug?
1		
2		
3		

What medications are you taking now? __None

	Name of Medication	Strength(ml,mg,cm)	Reason	How may times a day
1				
2				
3				
4				
5				
6				

Social History

1. Are you? __Married __Single __Divorced __Widowed
2. How may children do you have?___Are you pregnant now? Yes/No Due Date?____
3. Current occupation________ How long?__________ Noise Exposure__mild__moderate__severe
4. Do/did you smoke or chew tobacco? Yes / No How much?___ How long?______
5. When did you quit smoking or chewing tobacco?__________________
6. How much alcohol do you drink per week?_________________ What type?_________________

Consent For Medical Treatment----This is good for my lifetime

My permission is given today for any medical treatment, including but not limited to, examination injections, Diagnostic testing, medical procedures, as may be deemed advisable by members of the staff of the Thomas St. Medical Clinic.

Name of Patient____

Signature of Patient, Parent, or Guardian____

Date________________

Notice of Privacy Practices

I have read the Noticy of Privacy Practices and I have been provided an opportunity to review it.

Name of Patient__________________________________ Birthdate____________________________

Signature of Patient, Parent or Guardian_____________________________ Date_______________

I authorize these following people to access my medical records
____
____
____

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Financial Policy

Thomas St. Medical Clinic is committed to providing you with the best possible care. In an effort to better serve you while keeping our overhead cost down, we have adopted the following financial policy. Please read and familiarize yourself with this policy so that future misunderstandings Discrepancies regarding our billing and payment can be avoided. If you have questions regarding the billing, please do not hesitate to speak with the Billing Specialist.

All Co-Payments, Co-Insurances and Deductibles will be collected at the time of service. Please refer to your insurance company's Provider Directory to see if we participate with your plan.

- Please Remember: Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. You are personally responsible for any bill or portion thereof, not paid by a third party insurance carrier or Medicare.

We are billing your insurance carrier for you. Thomas St. Medical Clinic wants to make sure you understand that any balance on your account is your full responsibility. If your insurance carrier has not paid in thirty days, the balance will be the patient responsibility and payment in full will be expected.

If we do not participate with your plan, you will be required to pay in full at the time of services, unless payment arrangements have been made prior to your visit.

A service fee of $25.00 will be accessed for each returned check.

Patients Name:____

Please Print

I have read the above policy and understand my financial responsibilities in exchange for medical care provider by Thomas St. Medical Clinic.

Patient/Parent/Guardian ____ Date:____/____/____