

**Medications**

1. Prescription Medication:

Drug Name	Strength	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Non-Prescription Medication:

Drug Name	Strength	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Are you taking any vitamin or herbal supplements?  Yes  No

If Yes Please List:

_____	_____	_____
_____	_____	_____
_____	_____	_____

7710 Wolf River Circle  
Germantown, TN 38138



901-685-5969  
Fax: 901-685-6424

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Martial Status: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_ Work #: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Spouse Birth Date: \_\_\_\_\_

Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_ Work #: \_\_\_\_\_

Person to notify if emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred by \_\_\_\_\_ Family Physician: \_\_\_\_\_

Religious Preference \_\_\_\_\_

## Assignment of Benefits

I request that the payment of authorized Medicare benefits and all group insurance be made directly to C. Michael Jones, MD, PC for services provided to me by The Jones Clinic. I understand that I will be financially responsible for charges not covered by this assignment.

This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Consent to release Health Information

I authorize C. Michael Jones, MD, PC to disclose my identifiable health information to my insurance company and/or others for purposes of treatment, payment, and healthcare operations as described in the HIPAA Notice of Privacy Practices. Further, I authorize C. Michael Jones, MD, PC to disclose my identifiable health information for the other purposes listed under "How We May Use and Disclose Health Information About You" section of the HIPAA Privacy Notice. I authorize C. Michael Jones, MD, PC to speak to the following family members/friends regarding my medical care.

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Name/Relationship

\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Phone#

I authorize any holder of health information about me to disclose this information to C. Michael Jones, MD, PC for purposes of treatment, payment, conducting quality assessment, and improvement of activities, conducting population-based activities related to improving health, conducting case management and care coordination, and reviewing the competence, conduct or qualifications of health care professionals. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Medical History

Name: \_\_\_\_\_ Date \_\_\_\_\_

1. Allergies: \_\_\_\_\_

2. Immunizations: (Please X if you have received)

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Measles   | <input type="checkbox"/> German Measles | <input type="checkbox"/> TB skin test: |
| <input type="checkbox"/> Mumps     | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Tetanus       |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Influenza      |  |

3. Social Habits:      Smoke/Amount \_\_\_\_\_      Alcohol/Amount \_\_\_\_\_

4. Surgical History:

Date _____	Reason _____	Hospital _____
Date _____	Reason _____	Hospital _____
Date _____	Reason _____	Hospital _____

5. Have you ever had a blood transfusion?  Yes  No    When \_\_\_\_\_

6. Conditions: Have you ever had any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Unexpected weight change of more than 10 lbs | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Persistent or swollen glands or lumps        | <input type="checkbox"/> Pain w/ urination     |
| <input type="checkbox"/> Irregular or fast heartbeat                  | <input type="checkbox"/> Black or tarry stools |
| <input type="checkbox"/> Chest pain or tightness                      | <input type="checkbox"/> Nausea or vomiting    |
| <input type="checkbox"/> Changes in appetite                          | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Frequent constipation/diarrhea               | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Diabetes                                     |  |

7. Family History:

- Cancer  
Who \_\_\_\_\_ What Type: \_\_\_\_\_  
Who \_\_\_\_\_ What Type: \_\_\_\_\_
- High blood pressure  
 Diabetes:  
 Blood disorders  
Who \_\_\_\_\_ What Type: \_\_\_\_\_

8. Do you have a Living Will?  Yes  No