Jean L. Tan, MD • Primary Care Clinic, LLC
125 COOL SPRINGS BLVD, SUITE 230, FRANKLIN, TN 37067
PHONE: 615-771-8549 FAX: 615-771-8551

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.	Previous Name:
Mailing Address:		Apt #:	
City/State/Zip:			
Home Phone:	**Cell Phone:** *Can we leave a message regarding your medical care & test results?* ***Y*** ***N***		**Work Phone:**
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Preferred Pharmacy Location:

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Address:	Policy Holder Address:

I have read and agree to Primary Primary Care Clinic (PCC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PCC all money to which I am entitled for medical expenses related to the services performed from time to time by PCC, but not to exceed my indebtedness to PCC. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PCC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Primary Care Clinic's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ Date_____

Printed Name of Responsible Party:_____

PRIMARY CARE CLINIC, LLC
125 COOL SPRINGS BLVD, SUITE 230, FRANKLIN, TN 37067

JEAN L. TAN, MD
PHONE: 615-771-8549 FAX: 615-771-8551

New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
***Example:** Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Notice of Privacy Practices for Primary Care Clinic, LLC

(Referred to herein as the "Clinic")

This Notice is first in effect on April 14, 2003.

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. The *Clinic* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

    a. For treatment – The nurse obtains treatment information about you and records in chart. The physician may need to consult another specialist regarding your care and treatment and share your information.

    b. For payment – Our office staff will relay information to your health insurance payor to obtain payment for the services provided to you here at the *Clinic* and in the hospital.

    c. For health care operations – Periodic reviews by *Clinic* staff of both your clinical and your financial information will be conducted to monitor for accuracy, safety and appropriateness.

2. The *Clinic* is permitted or required, under specific circumstances, to use or disclose protected health information without the Patient's written authorization. In addition to disclosures for treatment, payment and operations, the *Clinic* may be required to make disclosures for purposes of workers' compensation, public health, law enforcement or similar state or federal laws or ordinances.

3. Other uses and disclosures will be made only with the Patient's written authorization, and the Patient may revoke such authorization.

4. The *Clinic* may contact the Patient to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to the Patient or patient.

5. The Patient has the following rights regarding protected health information:

    a. The right to request restrictions on certain uses and disclosures of protected health information. **The *Clinic* is not required to agree to a requested restriction, however.**

    b. The right to receive confidential communications of protected health information, as applicable.

    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

    d. The right to amend protected health information, as provided in the Privacy Regulation.

    e. The right to receive an accounting of disclosures of protected health information.

    f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to a Patient who has agreed to receive the Notice electronically.

6. The *Clinic* is required by law to maintain the privacy of protected health information and to provide Patients with notice of its legal duties and Privacy practices with respect to protected health information.

7. The *Clinic* is required to abide by the terms of the Notice currently in effect.

8. The *Clinic* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that the *Clinic* maintains.

9. The *Clinic* will provide Patients or patients with a revised Notice by providing copies of the revised Notice at the *Clinic's* front desk.

10. Patients may complain to the *Clinic* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the *Clinic*, if they believe their privacy rights have been violated. A brief description of how the Patient may file a complaint is as follows: Direct a written copy of the facts and allegations of your complaint to the attention of the **HIPAA Privacy Officer** at the address below or you may telephone the **HIPAA Privacy Officer,** Jean L. Tan, MD directly at **615-771-8549,** 125 Cool Springs Blvd, Ste 230, Franklin, TN 37067 or to Office of Civil Rights, US Dept. of Health and Human Services, 200 Independence Ave, SW, Room 509F, HHH Bldg, Washington, DC 20201.