201.8

Mc
Family Medicine

McMillion Medical Group
400 Whitesport Drive, Suite 201, Huntsville, AL 35801 Phone (256) 489-3836 Fax (256) 489-3940
David McMillion, MD Jessica Walters, CRNP Tiaya Lang, CRNP Emory Coleman, CRNP

Patient Registration

Name: _____ Referred Here By: _____

Address: _____City:_____ State: _____ Zip: _____

Home Phone: _____Cell:_____ Gender: _____ DOB: _____

Email: _____

Preferred Language: _____ Race: _____ Circle one: Hispanic or Non-Hispanic

Age: _____ SSN: _____ Drivers Lic. #:_____ Marital Status: _____

Employer: _____ Occupation: _____ Work Phone: _____

Employer Address: _____ Date of Employment: _____

Spouses Name: _____ Spouses Employer_____

Spouses Occupation: _____ Spouses Work Phone: _____

Emergency Contact: _____Relation:_____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Group#_____ Contract#:_____ Co-pay_____

Name of Insured: _____ Relation to Patient: _____

Sex: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

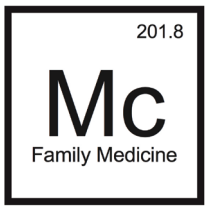
Group#_____ Contract#:_____ Co-pay_____

Name of Insured: _____ Relation to Patient: _____

Sex: _____ DOB: _____ SSN: _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize McMillion Medical Group to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to the party who accepts assignment. I certify that the information I have reported with regard to the patient's insurance coverage is correct.
I hereby acknowledge that I accept legal responsibility for all changes in connection with medical care provided by McMillion Medical Group to myself, my minor child or as guardian of the above patient. I understand that my insurance company may not reimburse all of my charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State / Federal law. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency.

Signed_____ Date: _____



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Patient Health History Ages 0-14

Name:_____ **Date of Birth:**_____ **Today's Date:**_____
Last Doctor:_____ **Reason For Leaving:**_____
Other Doctors (Specialists):_____
Child's Dentist and last visit:_____
Current Symptoms:_____
_____
Drug or Food Allergies (What happens to your child?):_____
_____

Past Medical History (Check or Write In)

☐ Allergies (Seasonal)	☐ Diabetes	☐ Seizure Disorder
☐ Anemia	☐ Ear Infections	☐ Stroke
☐ Asthma	☐ Fractures	☐ Thyroid Disease
☐ Birth Defect	☐ GERD (Reflux)	☐ Ulcerative Colitis
☐ Bleeding Disorder	☐ Heart Disease	☐ Urinary Infections
☐ Blood Clots	☐ High Blood Pressure	☐ Venereal Disease (STD)
☐ Breast Lump	☐ High Cholesterol	☐ Other
☐ Bronchitis (RSV)	☐ HIV	_____
☐ Cancer	☐ Liver Disease	_____
☐ Crohn's Disease	☐ Migraines	_____
☐ Depression	☐ Psychiatric Disease	_____

Surgeries

Surgery	Date / Location	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth History

Is this your child by birth?_____ **Adoption?** _____ **Stepchild?** _____ **Other?** _____
Birth Weight: _____ **APGAR's (if known)** _____ **Method of Delivery** _____
Born at _____**weeks of pregnancy? Pregnancy or delivery complications?** _____

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Patient Health History Ages 0-14 (Continued)

Name:_____ Today's Date:_____

Medications

Preferred Pharmacy:

Local:_____

Mail Order:_____

Medication: *(Lisinopril)*	**Strength:** (10 mg)	**Instructions:** (One pill by mouth once per day)	**30/90 Days?**

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Patient Health History Ages 0-14 (Continued)

Name:_____ Today's Date:_____

Development

At what age did your child: Sit alone_____ Walk alone _____ Start talking _____ Toilet Train_____
Current School: _____ Current grade:_____
First menstrual period (girls) :_____

Nutrition

Was (is) your child breastfed (ing)? _____ If so, for how long? _____
Has your child has any feeding problems? _____
How many ounces of milk per day? _____ How many ounces of juice per day? _____
Please describe your child's diet:
_____
_____

Family History

In each box please write age of disease onset	Addiction	Anxiety	Arthritis	Bleeding Disorder	Cancer (Type)	Colitis	Dementia	Diabetes	Eye Disease	Heart Attack	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Lung Disease	Migraines	Osteoporosis	Psychiatric Disease	Stroke	Thyroid Disease	Other
Mother																						
Father																						
Sister																						
Brother																						
Grandmother																						
Grandfather																						

Habits / Exposure

Who in the household smokes? _____
Any exposure to lead? (Old house, peeling paint, etc.) _____
How many hours of TV per day? _____ Computer?_____ Video Games?_____
Does your child play any sports, and if so, which sports? _____
_____

What does your child do for fun other than sports? _____
_____
_____

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Patient Health History Ages 0-14 (Continued)

Name:_____ Today's Date:_____

Symptoms (in the last 6 months)

General

- Fever ☐
- Chills ☐
- Fatigue ☐
- Weight loss ☐
- Skin changes ☐

EENT

- Hearing changes ☐
- Vision changes ☐
- Double vision ☐
- Ringing in ears ☐
- Dizziness ☐
- Eye pain ☐
- Ear pain ☐
- Nose bleeds ☐
- Hoarseness ☐

Cardiovascular

- Chest pain ☐
- Chest tightness ☐
- Irregular beat ☐
- Rapid heartbeat ☐
- Ankle swelling ☐
- Varicose veins ☐
- Exercise intolerance ☐

Pulmonary

- Persistent cough ☐
- Wheeze ☐
- Blood in sputum ☐
- Short of breath ☐
- Painful breathing ☐
- TB exposure ☐

Gastrointestinal

- Poor appetite ☐
- Swallowing problems ☐
- Heartburn ☐
- Vomiting ☐
- Constipation ☐
- Diarrhea ☐
- Gas ☐
- Bloating ☐
- Excessive thirst ☐
- Hemorrhoids ☐
- Nausea ☐
- Stomach pain ☐
- Blood in stools ☐
- Blood in vomit ☐
- Change in stools ☐
- Tarry stools ☐

Musculoskeletal

- Joint pain ☐
- Joint swelling ☐
- Joint stiffness ☐
- Joint deformity ☐
- Muscle pain ☐
- Weakness ☐
- Muscle cramps ☐

Neurological

- Weakness on one side ☐
- Headache ☐
- Fainting ☐
- Seizures ☐
- Loss of balance ☐
- Tremor ☐

Genitourinary

- Painful urination ☐
- Blood in urine ☐
- Can't hold urine ☐
- Can't urinate ☐
- Weak stream ☐
- Going too often ☐
- Increased night time urination ☐
- Discharge: Penile / Vaginal ☐

Psychiatric

- Change in mood ☐
- Loss of pleasure ☐
- Can't sleep ☐
- Too much energy ☐

Immunizations:

Please attach copy of Blue Card or Immunization Records.

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Authorization for Release / Request of Protected Health Information

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

SSN#:_____ Patient's Phone #:_____

Date of Request: _____ Date Information Needed: _____

☐ **I Authorize David A. McMillion,MD**
To RELEASE information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, ZIP

_____
Phone and Fax #

OR

☐ **I Authorize David A. McMillion,MD**
To RECEIVE information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, ZIP

_____
Phone and Fax #

Reason for this request:

☐ **Healthcare** ☐ **Insurance** ☐ **Personal** ☐ **Other**

Type of Records Requested:

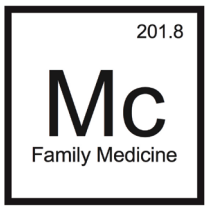
☐ **Consult** ☐ **Lab Results** ☐ **Imaging Results**
☐ **Discharge Summary** ☐ **Office Notes** ☐ **Other**
☐ **History and Physical** ☐ **Operative Report**

☐ **Medical Records Related to a Specific Illness or Injury and Date**_____

☐ **All Medical Records**

- **I understand that my right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.**
- **If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.**
- **Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.**
- **There may be a charge for requested records.**

_____ _____
Signature of Patient or Guardian **Date**



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Receipt of Privacy Practices
Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____, was provided a copy of McMillion Medical Group's Privacy Practices Notification. McMillion Medical Group may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize McMillion Medical Group to use or disclose my PHI in conjunction with McMillion Medical Group's treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature of Patient / Guardian **Date**

Further I hereby authorize and give my consent to McMillion Medical Group to leave messages on my answering machine / voicemail for the following (check all that apply):

Appointment Reminders	_____	**Prescription Refills**	_____
Medical Information	_____	**Test Results**	_____
Insurance / Payment Issues	_____	**Mail**	_____

I further authorize and give consent to McMillion Medical Group to communicate any of my PHI to the following person / persons:

Name	Relationship	Phone Number

_____ _____
Signature of Patient / Guardian **Date**