



**Patient Information Sheet**

**Welcome to our Practice**

Please complete the following information and sign at the appropriate place at the bottom of the page.

<b>Patient Information (please print)</b>			
<b>Date of Birth</b> _____	<b>Your Primary Ins</b> _____		
<b>Social Security Number</b> _____	<b>Your Secondary Ins</b> _____		
<b>Last Name</b> _____	<b>First Name</b> _____	<b>MI</b> _____	
Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Rev <input type="checkbox"/> Other, _____			
Suffix <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> Other, _____			
<b>Mailing Address</b> _____			
Apartment # _____	<b>City</b> _____	<b>St</b> _____	<b>Zip Code</b> _____ - _____
<b>Home Phone</b> (____) ____ - ____	<b>Work Phone</b> (____) ____ - ____	<b>Cell Phone</b> (____) ____ - ____	
Email Address _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Your Mother's Maiden Name _____			
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other, _____			
Student Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Institution _____			
<b>Primary Emergency Contact</b> NAME _____		Relationship _____	
<b>Home Phone</b> (____) ____ - ____	<b>Work Phone</b> (____) ____ - ____	<b>Cell Phone</b> (____) ____ - ____	
Other Emergency Contacts you wish us to have on file			
NAME _____		Relationship _____	
<b>Home Phone</b> (____) ____ - ____	<b>Work Phone</b> (____) ____ - ____	<b>Cell Phone</b> (____) ____ - ____	
NAME _____		Relationship _____	
<b>Home Phone</b> (____) ____ - ____	<b>Work Phone</b> (____) ____ - ____	<b>Cell Phone</b> (____) ____ - ____	
Employer _____ Job Title _____			
Employer's Address (with city, ST, zip) _____			
<b>INSURANCE INFORMATION (please provide your card{s} or copies of the front and back)</b>			
Primary Insurance _____		Telephone Number (____) ____ - ____	
Group or Policy Number _____		Subscriber or ID Number _____	
Subscriber Name _____		Effective Date _____ <input type="checkbox"/> Co-Pay \$ _____ <input type="checkbox"/> Deductible \$ _____	
Secondary Insurance _____		Telephone Number (____) ____ - ____	
Group or Policy Number _____		Subscriber or ID Number _____	
Subscriber Name _____		Effective Date _____ <input type="checkbox"/> Co-Pay \$ _____ <input type="checkbox"/> Deductible \$ _____	
<b>If you are the responsible party, mark "self"; otherwise, please complete the following information:</b>			
Patient's relationship to the responsible party <input type="checkbox"/> self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent SSN _____			
Guarantor's First Name _____		MI _____ Last Name _____	
Mailing Address _____			
City _____		State _____ Zip _____ Date of Birth _____	
<b>Home Phone</b> (____) ____ - ____	<b>Work Phone</b> (____) ____ - ____	<b>Cell Phone</b> (____) ____ - ____	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other, _____			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address _____	

**By your signature below, you understand and acknowledge that you will be responsible for the charges of any services provided that are denied, non-covered, or not paid by your insurance.**

Referred By: \_\_\_\_\_ **Signature:** \_\_\_\_\_



Original Date:

Dates Revised:

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name** (Last, First, M.I.):  M **DOB:**  
 F

**Marital status:**  Single  Partnered  Married  Separated  Divorced  Widowed

**Previous or referring doctor:** **Date of last physical exam:**

**Occupation:** **Spouse's Occupation:**

### PERSONAL HEALTH HISTORY

**Childhood illness:**  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

**Immunizations and dates:**

<input type="checkbox"/> Tetanus	<input type="checkbox"/> Zostavax	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gardasil	<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Influenza	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

**Recent and recurring medical problems:**

Most recent cholesterol/lipid test results:

Most recent PSA results (men only):

Date of last colonoscopy, location, and physician's name:

Date of last mammogram, location, and physician's name:

Other medical problems, including those diagnosed by another physician:


**Surgeries**

Year	Reason	Year	Reason

**Other hospitalizations**

Year	Reason	Year	Reason

**Have you ever had a blood transfusion?**  Yes  No

*Please turn to next page*

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**WOMEN ONLY**

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

(Women skip to the last section on this page)

**MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OTHER PROBLEMS****(MEN AND WOMEN)**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	



Release of Information TO another facility

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FROM ANOTHER FACILITY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_
Other Names Known By: \_\_\_\_\_

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to: \_\_\_\_\_ Address: 207-B Stonebridge Blvd \_\_\_\_\_ City & State: Jackson, TN
John B. Woods, M.D. Telephone: 731-664-7949 Fax: 731-664-6141 Zip: 38305

Attention:
CONFIDENTIAL

Purpose of Disclosure: [ ] Medical Care [ ] Insurance [ ] At the Request of the Patient
[ ] Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting
[ ] Other, Please Explain: \_\_\_\_\_

Description of Information to be Used or Disclosed:

Dates of Treatment: \_\_\_\_\_ Place of Treatment: \_\_\_\_\_

Choose From the Following:

- [ ] All Dictated Reports [ ] Lab (may include AIDS/HIV information) [ ] History & Physical
[ ] Radiology Reports [ ] Pertinent Summary [ ] Discharge Summary [ ] Pathology Reports
[ ] ER Record [ ] Consultation [ ] Anesthesia Record [ ] Billing Record
[ ] Operative/Procedure Report [ ] Entire Chart [ ] Photographs/Images [ ] Other (specify): \_\_\_\_\_

I understand that:

- 1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows John B. Woods, M.D. to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information; I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The Office of John B. Woods, M.D. is hereby released from any liability and the undersigned will hold John B. Woods, M.D. harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to John B. Woods, M.D. from the facility named above.

Signature of Patient \_\_\_\_\_

Signature of Patient's Authorized Representative \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

Description of Representative's Authority to Act for Patient \_\_\_\_\_



**John B. Woods, M.D.**  
Patient Authorization Form  
Advance Directives

**Patient Authorization:**

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
3. I allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
5. In the event the charges incurred are not paid-in-full when due and collection action is instituted whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all costs associated with such collection activity including, but not limited to, reasonable collection agency fees, attorneys' fees, and court costs.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.
8. I acknowledge full financial responsibility for services rendered by John B. Woods, M.D.

\_\_\_\_\_, 20\_\_\_\_  
Patient (or Guardian) Signature Date

\_\_\_\_\_, 20\_\_\_\_  
Witness (Office staff is considered your witness) Date

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**Advanced Directives:**

Do you have a living will or durable power of attorney?  No  Yes

If you do have a durable power of attorney, please identify: \_\_\_\_\_

Would you like us to give you a packet of information regarding advance directives?

No  Yes (Packet distributed)

\_\_\_\_\_, 20\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_, 20\_\_\_\_  
Witness (Office staff is considered your witness) Date



John B. Woods, M.D.  
Notification of Privacy Practices for Protected Health Information

1. I have been notified of the Medical Office of John B. Woods, M.D. Notice of Privacy Practices.
2. I authorize John B. Woods, M.D. to communicate or leave messages with the following person(s) regarding my visits, care, and/or account:

***(List all persons you wish to have access to your personal health information. This information will not be released, except by court order, to anyone who is not listed below.)***

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Other (describe)

3. Please indicate your permission for our communication with you regarding your personal health information. **Check all that apply.**
  - Telephone call to your home
  - Telephone call to your place of employment
  - Message at your home with the person who answers the phone
  - Message on your answering machine/voice mail at home
  - Message on your answering machine/voice mail at your place of employment
  - Facsimile

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Today's Date