F. Parker Thornton M.D. L.L.C.

Consent to Leave Phone Messages/Release of Information

Dear Patient,

F. Parker Thornton M.D. L.L.C. has adopted a policy that requires our staff to obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the HIPPA guidelines we need to guard against violating any patient confidentiality and protect our staff. If we do not have a signed consent on file we may only leave our name and phone number on an answering machine asking you to call back.

By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual. In order for us to relate any of your medical information to anyone other than yourself please check box #3 below.

☐ I give my consent to Dr. Thornton or his staff to release and/or leave messages regarding my care or lab results as necessary in the following situations. *Please check all that apply.*

- ☐ On answering machine **at home**
- ☐ On voice mail **at work**
- ☐ With _____ (relationship) _____

Patient Signature _____ Date _____

OR

☐ I do not consent to messages being left (other than name and phone number). Please contact me directly.

Patient Signature _____ Date _____

F. Parker Thornton M.D. L.L.C.

Patient Information

Date: **Date of Birth:** ☐**Male** ☐**Female** **Age:** ☐**Married** ☐**Single**

Last Name: **First Name:** **Middle Initial:**

Street Address: City:

State: Zip Code: Email:

Home Phone: Cell Phone: SSN:

Spouse/Parent Name: **Occupation:**

Patient Employer: **or School:**

Referral Source: ☐Insurance Provider ☐Internet ☐Family member/friend ☐Primary Care Physician

Primary Care Physician: Preferred Pharmacy:

Other family members previously treated:

Primary reason for your appointment:

Emergency Contact Name: **Phone:** **Relationship**

Is this a work related injury? ☐**yes** ☐ **no** **Is the injury due to an accident?** ☐**yes** ☐ **no**

Primary Insurance Information:

Insurance Company Name:

Insured Name: Relationship to Patient:

Policy/ID#: Group#:

Secondary Insurance Information:

Insurance Company Name:

Insured Name: Relationship to Patient:

Policy/ID#: Group#:

Insurance Release of Information, Authorization and Assignment: I request that payment of authorized Medicare or other insurance company/carrier be made on my behalf to F. Parker Thornton M.D. L.L.C. for any services furnished to me by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.(Section 1128B of the Social Security Act and U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature: _____ Date:

F. Parker Thornton M.D. L.L.C.

New Patient History Form (page 1 of 2)

Name: **Date of Birth:**

Height: **Weight:**

Reasons for Office Visit: (please list all symptoms)

1.
2.
3.

List All Medication Allergies:

List All Current Medications: (prescription and over the counter)

Past Medical History (Cholesterol, hypertension etc.):

Past Surgeries (at any age):

Family History (if deceased please indicate cause of death)

☐ Father: ☐ Mother : ☐ Siblings:

Do you have a family history of any of the following: (please check)

☐ Heart disease ☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Cancer ☐ Thyroid disease

☐ Other: ☐ Other:

Your Children: total # of living #deceased Serious diseases?

Personal Habits: (please check if yes)

- ☐ Do you smoke?, How much and how long?
- ☐ Did you previously smoke and when did you stop?
- ☐ Do you use smokeless tobacco? How often?
- ☐ Do you drink alcohol? How much and how often?
- ☐ Do you use illegal substances? What type?
- ☐ Do you exercise regularly?

F. Parker Thornton M.D. L.L.C.

New Patient History Form (page 2 of 2)

REVIEW OF SYSTEMS: Check ONLY if you have any personal history of any of these items.

CONSTITUTIONAL SYMPTOMS

- ☐ Good general health lately
- ☐ Recent weight change
- ☐ Decreased appetite
- ☐ Fever/night sweats
- ☐ Fatigue/weakness
- ☐ Headaches

EYES

- ☐ Eye disease or injury
- ☐ Wear glasses/contact lenses
- ☐ Blurred or double vision
- ☐ Glaucoma/cataracts

EARS/NOSE/THROAT

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problem
- ☐ Nose bleeds
- ☐ Mouth sore
- ☐ Sore throat or voice changes
- ☐ Swollen glands in neck

CARDIOVASCULAR

- ☐ Heart trouble
- ☐ Chest pain or angina pectoris
- ☐ Palpitation
- ☐ Shortness of breath with walking or lying flat
- ☐ Swelling of feet, ankles or hands

RESPIRATORY

- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing

PSYCHIATRIC

- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Change of bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements/constipation
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain
- ☐ Peptic ulcer (stomach or duodenal)

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty in walking

GENITOURINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Awaken at night to urinate
- ☐ Blood in urine
- ☐ Change in force of stream when urinating
- ☐ Incontinence or dribbling
- ☐ Sores or discharge
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Male-testicle pain/lumps
- ☐ Female – pain with periods
- ☐ Female – irregular periods
- ☐ Female – vaginal discharge
- ☐ Female - # pregnancies _____
- ☐ Female - # miscarriages _____

INTEGUMENTARY (skin, breast)

- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in nail color
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

NEUROLOGICAL

- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Shakes
- ☐ Paralysis
- ☐ Stroke
- ☐ Head injury

ENDOCRINE

- ☐ Glandular or hormone problem
- ☐ Thyroid disease
- ☐ Diabetes (insulin)
- ☐ Diabetes (non-insulin)
- ☐ Excessive thirst or urination
- ☐ Heat or cold intolerance

ALLERGIC/IMMUNOLOGIC

History of Skin Reaction or adverse reaction to?

- ☐ Penicillin or other antibiotics
- ☐ Morphine, Demerol, or other narcotics
- ☐ Novocain or other anesthetics
- ☐ Aspirin or other pain remedies
- ☐ Tetanus antitoxin or other serums
- ☐ Iodine, merthiolate or other antiseptic
- ☐ Other durgs/medications:

_____

_____

_____

F. Parker Thornton M.D. L.L.C.

Financial Policy

Payment Information

1. Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We file insurance claims as a courtesy to our patients.

2. If you have an HMO or PPO insurance requiring referral, you must have a completed referral form or number with you at the time of your appointment or you will be required to pay the entire fee at the time of service.

3. All co-pays and deductibles are to be paid the day of your appointment.

4. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts.

5. Fees are due and payable at the time of your appointments. For our patients we accept checks, cash, VISA and MasterCard.

6. Accounts become past due 60 days after your insurance pays. We reserve the right to send the account to a collection agency if the balance is not paid in full after 90 days.

I acknowledge that I have read, understand and agree to the terms of this document relating to insurance and payment of my bill.

_____ Date

Patient or Guardians Signature
(Signature required at time of appointment)