MUSCLE & JOINT MEDICINE

DOCTOR:_____
Appt date:_____

PATIENT'S PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Gender: MALE / FEMALE

LastName:_____Phone#:_____
First Name:_____Work orCell#:_____
Middle Name:_____Social Security #_____
Address:_____Birthday:_____
City:_____ State:_____Zip _____
Marital Status:_____Spouse Name:_____
Employer:_____Spouse Social #_____
Spouse Employer:_____Spouse work #:_____
E-Mail:_____Language:_____
Contact Preference: Phone / E-Mail / Mail Race:_____
Primary Insurance:_____ Ins #_____
Secondary Insurance:_____ Ins #_____

Previous Physician or Referring Physician_____

(Bring Ins. Cards, Medications, Medical Records, and New Patient Forms with you to your appointment)

Signature of Responsible Party _____ Date: _____
Person to notify in an Emergency(Not living in your household:

_____

Relationship_____ Phone# _____

Late Cancellation Policy: Patients are responsible for canceling all scheduled appointments within 24 hours. **Failure to keep an appointment without giving at least 24 hours notice will generate a charge of $25.00 to the patients account.** The patient is responsible for this charge, which is non-billable to the insurance company.

Responsible Party:_____ Relationship to Patient:_____

I hereby authorize Cullman Internal Medicine P.C. to furnish to the above insurance company'(s) all information, which said insurance company, may request. I hereby assign to Cullman Internal Medicine P.C., all money to which I am entitled for medical/surgical expense relative to the service rendered but not to exceed my indebtedness to the professional corporation. I understand that I am financially responsible to the said corporation for charges not covered by this assignment, I further agree, in the event of nonpayment, to bear the cost of collection and /or court cost and responsible legal fees, should this be required.

Patient Signature:_____
Parent/Guardian Signature:_____

PATIENT'S FAMILY HISTORY

IF LIVING IF DECEASED

Father: Age_____ Health _____ Age of Death _____ Cause _____

Mother: Age _____ Health _____ Age of Death _____ Cause _____

Siblings:

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Your Children

Name: _____ Sex: M F
Age: _____ Health: _____ Age at Death _____ Cause _____

Name: _____Sex : M F
Age: _____ Health: _____Age at Death _____Cause _____

Name: _____ Sex: M F
Age: _____ Health_____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health: _____ Age at Death _____Cause _____

Do you know of any blood relative who has or had (circle and give relationship)

Stroke _____ Epilepsy _____Heart Attack _____

Suicide _____ Cancer _____Goiter _____

High Blood Pressure _____Asthma _____ Hay Fever _____

Nervous Breakdown _____ Migraines _____ TB_____

Stomach Ulcers _____Kidney Disease _____Rheumatic Fever_____

Insanity _____Leukemia _____Diabetes _____

Arthritis _____ Bleeding Tendency _____

Congenital Heart Disorder _____ Colitis _____

PERSONAL HABITS (CIRCLE)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars How many years? _____
Yes No Do you usually drink over six(6) cups of coffee per day?
Yes No Do you regularly drink alcohol? 1 oz per day 2 oz per day 4 oz per day over 6 oz per day
BEER 1 bottle per day 2 bottles per day over 4 bottles per day
WINE 1 glass per day 2 glasses per day over 4 glasses per day

Yes No Do you have difficulty falling asleep?

SURGICAL HISTORY

What operations have you had?_____

_____

ALLERGIES

Name any drug you are allergic to and what type reaction each drug causes _____

_____

MEDICAL HISTORY

Write the names of any illness that have required hospitalization _____

_____

Write the names of any serious illnesses you've had that did NOT require hospitalization

_____

_____

List any serious injuries or accidents _____

_____

Yes	No	Have you ever fainted?	Yes	No	Have you ever had a convulsion?
Yes	No	Spells of dizziness?	Yes	No	Double Vision?
Yes	No	Spells of weakness of arm/leg?	Yes	No	Pain in ear?
Yes	No	Ringing in the ears?	Yes	No	Nosebleeds?
Yes	No	Do you frequently have Bleeding gums?	Yes	No	Do you frequently have a sore Tongue?
Yes	No	Do you frequently have Trouble swallowing?	Yes	No	Do you frequently have hoarseness?
Yes	No	Do you frequently have nausea and vomiting?			

Have you ever had shortness of breath:

Yes	No	Doing your usual work?	Yes	No	Which causes you to cough?
Yes	No	Climbing a flight of stairs?	Yes	No	Accompanied by wheezing?
Yes	No	Which awakens you at night?	Yes	No	Have you ever coughed up blood?
Yes	No	Do you have a chronic cough?	Yes	No	Do you cough up sputum?

Have you ever had chest pain or tightness:

Yes	No	When you exert yourself?	Yes	No	Which radiates down the arm?
Yes	No	When walking against the wind?	Yes	No	Which disappears if you rest?
Yes	No	When walking up a hill?	Yes	No	Which occurs only at rest?
Yes	No	After a heavy meal?	Yes	No	When walking fast?
Yes	No	When upset or excited?	Yes	No	When walking in cold weather?
Yes	No	Do you sleep on more than One pillow?	Yes	No	With Palpitations?

If you have chest pain or tightness please describe _____

_____

Have you recently had pain in the stomach which:

Yes	No	Occurs 1-2 hours after meals?	Yes	No	Awakens you at night?
Yes	No	Is brought on by eating fried food?	Yes	No	Is relieved by antacids?
Yes	No	Occurs while eating or Immediately after?	Yes	No	Is relieved by a bowel Movement?
Yes	No	Is relieved with milk or eating?	Yes	No	Causes loss of appetite?

If you had a change in bowel habits recently answer the following:

Yes	No	Crampy pain in abdomen?	Yes	No	Blood in stool?
Yes	No	Alternating diarrhea & constipation?	Yes	No	Ribbon-like stools?
Yes	No	Pain during or after bowel movement?	Yes	No	Black stools?
Yes	No	Require use of laxative or enema?	Yes	No	Mucous in stool?

Have you had:

Yes	No	Burning when urinating?	Yes	No	Loss of control of bladder?
Yes	No	Blood in urine?	Yes	No	Dark colored urine?
Yes	No	Trouble starting to urinate?	Yes	No	Trouble holding urine?
Yes	No	Frequent night urination?	Yes	No	A kidney stone?

Have you recently had:

Yes	No	Pain in calves of legs when walking?	Yes	No	Cramps in legs at night?
Yes	No	Pain in the big toe?	Yes	No	Varicose veins?
Yes	No	Phlebitis or inflames leg veins?	Yes	No	Swelling in the ankles?

Do you frequently have severe headaches? If yes, please answer the following:

Yes	No	Do they cause visual trouble?	Yes	No	Do they occur on one side?
Yes	No	Do they awaken you from sleep?	Yes	No	Do they feel like a tight band?
Yes	No	Do they hurt most in the back of the head/neck?			
Yes	No	Are they relieved by aspirin?			

TO BE ANSWERED BY WOMEN ONLY

Yes	No	Are you still having regular monthly menstrual periods?	When? _____
Yes	No	Have you ever had bleeding between your periods?	When? _____
Yes	No	Do you have very heavy bleeding with your periods?	
Yes	No	Do you feel bloated and irritable before your periods?	
Yes	No	Are you now on or have you ever taken birth control pills?	When? _____
Yes	No	Have you ever had a miscarriage?	When?_____
Yes	No	Have you ever had discharge from the nipple of your breast?	When?_____
Yes	No	Do you regularly have cancer test of the cervix?	Date of last test _____

How many children born alive? _____ How many miscarriages? _____

How many stillbirths? _____ How many C-sections? _____

How many premature births? _____ Any pregnancy complications? _____

Date of last menstrual period _____ Name of OB/GYN _____

TO BE ANSWERED BY MEN ONLY

Have you ever had

Yes	No	Treatment for genitals?	Yes	No	Discharge from the penis?
Yes	No	Hernia (rupture)?	Yes	No	Prostate trouble?
Yes	No	Loss of sexual activity? For how long? _____			

Briefly describe your present medical symptoms:

_____

_____

_____

_____

Muscle & Joint Medicine
Medication List

Please list all of your current medications including the name of your medication, the dosage amount and the directions. Example – Nexium 40 mg once per day. Please do not include dietary supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

MUSCLE & JOINT MEDICINE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ SSN: _____

_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose to the use and disclosure:

Please list the family members or others persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, x-rays, and treatment and /or reference to any mental or nervous disorders, drug, an/or alcohol abuse, or sexually transmitted disease.

_____ *Relationship:* _____

_____ *Relationship:* _____

_____ *Relationship:* _____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis ONLY in an emergency situation:

_____ *Relationship:* _____

_____*Relationship:* _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuel to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:_____

Cullman Internal Medicine, P.C.
1890 Alabama Highway 157, Suite 300
Cullman, Alabama 35058

William F Peinhardt, M.D.
Phillip W. Freeman, M.D.
L. James Hoover, M.D.
W. Michael Hall, M. D.
Naykala Ruse, M.D.
Lisa Ellard, CRNP
Kelley Johnson, CRNP
Rebecca Harris, CRNP

C. Anthony Rutledge, M.D.
Lane Friedman, M.D.
Melinda Hart, M.D.
Jeremy Stidham, M.D..
Bethany Lamar, CRNP
Anne Armstrong, CRNP
Marcia Tillman, CRNP
Allison Newman, M.D.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC EXTENDED PATIENT SIGNATURE AUTHORIZATION

_____ _____

Name of Beneficiary HI Claim Number

I request payment of authorized Medicare benefits on my behalf for any services furnished me by Cullman Internal Medicine, P.C. I authorize any holder of medical and other information about me to release to Medicare and its agents, any information needed to determine these benefits for related services.

_____ _____

Date Patient Signature