NexGen Health and Wellness / 7424 Hwy 64, Suite 118 / Bartlett, TN 38133
Ph: (901)-244-6631 F: (901)-244-6573
www.nexgenhealthandwellness.com

PATIENT INFORMATION RECORD

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: ____ / ____ / ____ SEX: Male: _____ Female: _____ Marital Status: **M W D S**

Address: _____City: _____ State: _____ Zip: _____

SSN:_____ Primary Phone: _____ Cell Phone: _____

Email address: _____ Referred by: Walk-in, Family/friend, website, social media, other: _____

Preferred Pharmacy: _____ Phone: _____

Occupation: _____ Employer: _____

Preferred Method of Communication: Home Work Cell Other: _____

In case of Emergency, contact: Last Name: _____ First Name: _____

Emer. Contact Phone# (_____) _____-_____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy Holder: Last_____ First _____ MI __

Insurance ID#: _____ Group#:_____ Policy Holder DOB: _____

Secondary Insurance Name: _____ Policy Holder: Last_____ First _____ MI __

Insurance ID#: _____ Group#:_____ Policy Holder DOB: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and agree to be financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Signature (patient or, if minor Signature of guardian)	**Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize NexGen Health and Wellness and its employees, agents or associated healthcare practitioners to disclose my protected health information to the following individuals:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

I understand that:

- Once this facility discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable to federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). Furthermore, my records are protected and cannot be disclosed without written permission.

Signature	**Date**

-----**PLEASE SEE REVERSE SIDE**-----

Medical History Sheet

Patient Name: _____ **Chart**: _____

Height: _____ **Weight:** _____

Medical History: (please mark all you have ever been treated for or are currently being treated)

❑ **No Medical History**

General
- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ MRSA
- ❑ Systemic Lupus Erythematosus
- ❑ Transplant Recipient, Organ:_____

Cardiovascular
- ❑ Atrial Fibrillation
- ❑ Blood Transfusion, Date: _____
- ❑ Chest Pain
- ❑ Congestive Heart Failure (CHF)
- ❑ Coronary Artery Disease (CAD)
- ❑ Clot in Leg or Lung
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Valve Disorder, Type: _____
- ❑ High Blood Pressure (HTN)
- ❑ High Cholesterol

Endocrine/Metabolic
- ❑ Diabetes, Type I or II
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Low Testosterone

Respiratory
- ❑ Asthma
- ❑ COPD
- ❑ Pneumonia
- ❑ Sinus Conditions
- ❑ Sleep Apnea
  - ❑ Use CPAP

Gastrointestinal
- ❑ Acid Reflux/GERD
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Stomach Ulcer
- ❑ Ulcerative Colitis

Genitourinary
- ❑ Chronic Kidney Disease
- ❑ Genital Herpes
- ❑ Genital Warts
- ❑ Interstitial Cystitis
- ❑ Kidney Stones
- ❑ Renal Failure
- ❑ STD:_____
- ❑ Urinary Tract Infections

Men's Health
- ❑ BPH
- ❑ Erectile Dysfunction
- ❑ Prostatitis
- ❑ Previous Testosterone USE: _____

Women's Health
- ❑ Menopause
- ❑ PCOS

Musculoskeletal
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Chronic Back Pain
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Neuropathy

Neuro/Psych
- ❑ Anxiety / Depression
- ❑ Headache/Migraines
- ❑ Insomnia
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disorder
- ❑ Seizures
- ❑ Stroke/TIA

Cancer
- ❑ Bladder
- ❑ Colon/Rectal
- ❑ Female, Type:_____
- ❑ Kidney
- ❑ Lung
- ❑ Prostate
- ❑ Other: _____

Other Medical History: _____

_____

------- **PLEASE SEE REVERSE SIDE**-------

Medical History Sheet

Patient Name: _____ **Chart**: _____

Surgical History: (please list <u>ALL</u>surgeries you have ever had) *if additional space needed, please ask.

Surgery	Date

Social History: (circle or fill in appropriate response)

Current Alcohol Consumption: No Yes _____ drinks per week
History of Alcohol Abuse: No Yes _____ days/months/years sober
Current Tobacco Use: No Yes cigarettes/cigars **_____packs per day _____cigars per day**
History of Tobacco Use: No Yes Age start? _____ **Age stop? _____**
Smokeless Tobacco Use: No Yes # Cans of Dip per day _____

Recreational Drug Use:
____None ____Current, name substance(s)_____

Daily Fluid Intake: _____ 8 oz. cups of coffee per day _____ 8 oz glasses of water per day
_____ 8 oz. glasses of tea per day _____ 8 oz. glasses of milk per day

Activities/Exercise: ___ None ___ Mild Exercise ___ Occasional vigorous exercise ___ Vigorous 6x/week

❑ N/A **Male Health History**:
Unsure: ____ Date of Last PSA: _____ Date of Last Prostate Exam: _____ Normal _____ Abnormal _____

Family History: (please list type of cancer) *if additional space needed, please ask

Condition	*Relative: M, F, Sister, Brother, MGM, MGF, PGM, PGF*	*Living*	*Age passed*
Arthritis			
Cancer: (Type)_____			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney Failure			
Stroke			
Thyroid Disorder			
Other:			

Patient Medication List

Patient Name: _____ **Chart**: _____

Date: _____

Local Preferred Pharmacy: _____ Pharmacy Phone: _____

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies

(Please list all known allergies, reactions and cause)

_____ **No Known Drug Allergies (X or initials)**

Drug	Type of Reaction (Mild, Moderate, Severe)

Revised 10/30/19

Patient Name: _____ **Chart:** _____

NexGen Health and Wellness ----HIPAA – Notice of Privacy Practices

NexGen Health and Wellness is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Summary of Rights and Obligations Concerning Health Information.
NexGen Health and Wellness is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by NexGen Health and Wellness. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- ✓ plan your care and treatment;
- ✓ provide treatment by us or others;
- ✓ communicate with other providers such as referring physicians;
- ✓ receive payment from you, your health plan, or your health insurer;
- ✓ make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- ✓ make you aware of services and treatments that may be of interest to you; and
- ✓ comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

<u>You have the right to</u>:
- ❖ ensure the accuracy of your health record;
- ❖ request confidential communications between you and your therapist and request limits on the use and disclosure of your health information; and
- ❖ request an accounting of certain uses and disclosures of health information we have made about you.

<u>We are required to:</u>
- ❖ maintain the privacy of your health information;
- ❖ provide you with notice, such as this Notice of Privacy Practices, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- ❖ abide by the terms of our most current Notice of Privacy Practices;
- ❖ notify you if we are unable to agree to a requested restriction; and
- ❖ accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Disclosure of Your Health Care Information:

We may disclose your healthcare information as necessary to comply with State Workers Compensation laws, Public Health Authorities, Emergency Situations, Judicial & Administrative Proceedings, Law Enforcement, Medical Examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude for referrals, and change of ownership. I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures.

I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

Revised 10/30/2019

Weight Loss Consent Form

Patient Name: _____ **Chart**: _____

I, _____ authorize Dawn Barrom, ACNP of NexGen Health & Wellness and her designated associates or assistants, to help me with my weight reduction efforts. I understand that the success of my weight loss depends upon my effort and there are no guarantees of weight loss or how long I will maintain any weight that is lost during the course or after the course of the weight management program. Obesity may be a chronic condition that may require permanent changes in behavior including dietary and exercise habits to be treated successfully.

The weight loss program may include a reduced calorie diet, exercise program, appetite suppressant medications, and behavior modifications. I do understand that any weight loss regimen may come with risks as well as benefits. Risks of a weight loss program may include but are not limited to fatigue, headache, trouble sleeping, dry mouth, diarrhea, constipation, anxiety, depression, elevated blood pressure, diabetes, heart irregularities/arrhythmias, and very rarely death. However, risks of remaining overweight or obese may include elevated blood pressure, high cholesterol, diabetes, heart disease, heart attack, cancer, arthritis, sleep apnea, and sudden death.

The weight loss program may include FDA approved appetite suppressant medications. These medications may be used in conjunction with other medications and for longer periods of time. We make no therapeutic or medical claims on these products.

I have read and fully understand this consent form. I realize that I should not sign the consent form if all items have not been explained to me. My questions have been answered to my complete satisfaction.

_____ _____ _____/_____/_____

Print Name **Signature** **Date**

_____

Witness

Revised 10/30/2019