CONFIDENTIAL
PATIENT HISTORY

CASE HISTORY

DATE ____________

FILL OUT COMPLETELY

Name ______________________________ Home Phone ______________________

Cell Phone ______________________________ Cell Carrier ______________________

Social Security ___ ___ ___ ___ ___ ___ ___ ___ ___ E-mail ______________________________

Address ______________________ City ________________ Zip Code ________

Age ______ Birth Date ____________ Marital: M S W D How Many Children? ________

Occupation: ______________________ Employer ______________________________

Address ______________________________ Office Phone ______________________

Name of Spouse ______________________ Occupation ______________________

Employer ______________________ Address ______________________

Name of Nearest Relative ________________ Address ______________ Phone ________

Referred by ______________________________

Is the condition due to injury or sickness arising out of employment? ______________________

Is the condition due to injury or sickness arising out of auto or other accident? ______________________

Days lost from work? ________ Date symptoms appeared or accident happened? ______________

Have you ever had a similar condition? Yes ________ No ________ If yes, when and describe ________
____

Date of last physical examination? ______________________________________

Purpose of this appointment ______________________________________

Other doctors seen for this condition ______________________________________

Have you been treated for any health condition by a physician in the last year? YES ( ) NO ( )

Describe ______________________________________

What medications or drugs are you taking? ______________________________________

I consent to the treatment necessary for proper care. I consent to the use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.
I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself. Furthermore, I understand that Memphis Spine and Rehab Center will prepare an necessary reports and forms to assist me in making collection from the insurance company and that payments shall be paid directly to Memphis Spine and Rehab Center which will be credited to my account upon receipt.
By signing this statement, I agree to be responsible for payment of services not paid. "In the event of default, I agree to pay all collection cost, including attorney fees and/or collection company cost."
I attest to the accuracy of the information on this page.

Health Insurance: YES ( ) NO ( ) Company ______________________________
Patient's Signature ______________________________ Date ____________

Guardian's Signature Authorizing Care ______________________ Date ____________

MEMPHIS SPINE AND REHAB CENTER

8132 CORDOVA RD, STE 102
CORDOVA, TN 38016
901-751-0939

HIPAA / PRIVACY PRACTICES

SECTION A: THE PATIENT INFORMATION

NAME:____

ADDRESS:____

TELEPHONE:____________________EMAIL:____________________

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, ______________________________, acknowledge that I have an understanding of the Notice of Privacy Practices from Memphis Spine and Rehab Center.

Signature:__________________________Date:________________

SECTION C: HIPAA

Who may we speak with regarding your medical care/appointments?

____**(Please Print)**

Relationship: ______________________________

I am authorizing the staff of Memphis Spine and Rehab to speak to the above persons on my behalf. The person listed above is able to gain information of my care or adjust appointments on my behalf. If patient is a minor (Under the age 17 is considered a minor)

Power of Attorney Information for: ______________________________

Date of Expiration:________________ **for Patient:**________________________

If you have a power of attorney for the patient please provide us with a copy of the power of attorney it must state it is for healthcare. If you are a representative for the patient due to translation please note that on the line identified as relationship listed above. If patient is unable to sign this form due to a medical condition please note below.

Patient Signature: ______________________________**Date:**________________

POA/ Patient Representative: ______________________________

Note:____

____