harpeth family Medicine @home

Tomorrow's healthcare, today.

Dear Patient or Caregiver,

Thank you for

Please complete all forms and return to our office before your appointment. We will also need:

□ Completed new patient paperwork
□ Driver's license or other proof of your address
□ Insurance card(s)
□ Telemedicine consent form

Directions:

From Nashville take I-40E (I-65S) to exit 69 and merge onto Moore's Lane towards TN-441. Continue on Carothers Parkway. Turn Right at Isabella Lane (across from Shell Gas Station). Office is located on Left in Liberty Place.

From Columbia take I-65N to exit 69. Turn Right onto Moore's Lane. Continue on Carothers Parkway. Turn Right at Isabella Lane (across from Shell Gas Station). Office is located on Left in Liberty Place.

For further information, please call our office at 615-309-0080, email at admin@harpethfamilymedicine.com, or visit our website at www.harpethfamilymedicine.com

We look forward to seeing you at your appointment!

Dr. Srinivas Nimmagadda

8115 Isabella Lane, Suite 11 Brentwood, TN 37027

Tel: 615-309-0080 Fax: 615-932-7270

			PATIENT INFORMATION:
Legal Name (First Middle Last):			
Preferred Name:		SSN:	
Birthdate:	Birth Gender: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Partner	
Mailing Address:			
Phone: ❑ No	Okay to leave a msg? ❑ Yes	Alt Phone:	
Email Address:		Okay to email you about your medical care? ❑ Yes ❑ No	
Preferred Language: ❑ English ❑ Other: _____			

Ethnicity (please check all that apply): q African American or Black q Asian q Caucasian/White q Native American or Alaska Native q Native Hawaiian or Pacific Islander q Decline to specify q Other:	Race: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Preferred Local Pharmacy Name and Telephone: Mail Order Pharmacy Name and Telephone:

Legal Name (First Middle Last):

SSN:	Birthdate:	Phone:

Mailing Address (if different):

In order to maintain an accurate and up to date medical record, we request permission to query outside resources to obtain a list of your medications. ☐ I consent. ☐ I do **not** consent. I understand that it will be responsibility to bring an up-to-date list (including dosages) or the bottles of all of the medications and supplements I take to every appointment.

I received Harpeth Family Medicine's *Notice of Privacy Practices,* and I understand that I may
Patient Name or Legal Guardian:

Patient/Guardian Signature:	*Date:*

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.
Patient Name or Legal Guardian:

Patient/Guardian Signature:	Date:

If you would like us to bill your insurance for your visits, please give us copies of the front and back of all your insurance cards otherwise we will bill you per our self-pay

Are you here today because you would like a: ❑ a new primary care physician ❑ palliative care consult

How did you hear about our practice?

MEDICATIONS, VITAMINS, & SUPPLEMENTS

Name of Medication & Strength:	Frequency:

CURRENT/PAST MEDICAL ISSUES

Condition/Disease:	Year Diagnosed:	Condition/Disease:	Year Diagnosed:

ALLERGIES ❑ NONE	
Medication/Substance Allergic To:	**Reaction:**

SURGICAL HISTORY & HOSPITALIZATIONS	

FAMILY HISTORY ❑ NONE			
Relative:	**Medical Conditions:**	**C**	**Age at**
Father			
Mother			
Brother(s)			
Sister(s)			

Siblings:	# of Brothers:	# of Sisters:	□ Healthy
Children:	# of Sons:	# of Daughters:	□ Healthy

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Religion/Faith: _____ **Is your faith important to you?** □ Yes □ No

Does your faith affect your health care decisions? ❑ Yes ❑ No

Advance Directives: (attach copy of document)

Durable power of attorney for healthcare? □ Yes □ No
Name/relationship:_____

Living will? □ Yes □ No **Do not resuscitate form?** □ Yes □ No

Highest Level of Education: _____ **Retired:** □ Yes (Year: _____)

Occupation or occupation you most recently retired from:

Tobacco: *e.g. cigar, cigarette, chewing, pipe, or vaping* □ **Never** □ **Quit** (Date: _____)	**Alcohol Use in the Last Year:** □ **None** □ **# Drinks/week** _____

Type of Residence: □ Home □ Independent Living Facility □ ALF □ SNF

If you live at home, who do you live with? □ Alone □ Significant other □ Family □ Friends

Is there anything else related to your healthcare you think we should know: *Examples include specific dietary guidelines your follow, exercise routines, difficulty with getting dressed or preparing meals, refuse blood transfusions, etc.)*

CAREGIVER QUESTIONS

Do you feel you are able to provide the care your relative needs? □ Yes □ No

Do you feel you have time to take care of yourself? □ Yes □ No

Comments:

DISEASE PREVENTION AND HEALTH

	Year		Year		Year
Influenza Vaccine (Flu)		Mammogram		Aneurysm Screen	
Pneumovax (Pneumonia)		Pap Smear		Eye Exam	
Prevnar (Pneumonia)		Bone Density		Dental Exam	
TDaP (Tetanus)		Colonoscopy		STD Test	
Shingrix (Shingles)		Cologuard		HIV Test	
Gardasil Vaccine		Cardiac Stress Test		Hepatitis C Screen	

DURABLE MEDICAL EQUIPMENT

List any medical equipment utilized such as CPAP, oxygen, hospital bed, bedside commode, feeding tube pump, walker,

Equipment:	Supplier Name and Phone:

HOME CARE/ HOME HEALTH/HOSPICE AGENCY INFORMATION

Agency Name: _____

Agency Phone: _____

Nursing services	□ Yes □ No
Home health aide	□ Yes □ No
Physical therapy	□ Yes □ No
Speech therapy	□ Yes □ No

REVIEW OF			
GENERAL □ Fever □ Chills □ Fatigue □ Weakness □ Change in appetite □ Weight loss □ Weight gain	**SKIN** □ Rash □ Itching □ Acne □ Bed sore □ Skin discoloration □ Blistering or Hives □ Change in hair or nails	**HEAD** □ Headaches □ Migraines □ Change in vision □ Eye pain □ Watery eyes □ Tooth pain □ Dentures	**ENT** □ Hearing loss □ Hearing aids □ Ringing in the ears □ Nosebleeds □ Runny or Stuffy nose □ Sore throat
HEART □ Chest pain □ Palpitations □ Leg swelling □ Leg cramping □ Trouble breathing while lying flat □ Uncontrolled blood pressure	**LUNGS** □ Cough □ Shortness of breath □ Sputum production □ Wheezing □ On oxygen □ Pain with inspiration □ On CPAP	**GASTROINTESTINAL** □ Heartburn □ Nausea or Vomiting □ Bloating □ Abdominal pain □ Diarrhea □ Constipation □ Blood in stool □ Painful bowel	**GENITOURINARY** □ Urinary burning □ Urgency □ Frequency □ Blood in urine □ Incontinence □ Waking up at night to pee
MUSCULOSKELTAL □ Muscle aches □ Back pain □ Fall within past year □ Pain intensity 1 2 3 4 5 6 7 8 9 10 □ Joint pain Location:	**ENDOCRINE** □ Easy bruising □ Extreme thirst □ Irregular periods □ Diabetic □ Cold intolerance □ Heat intolerance □ Night sweats	**NEUROLOGICAL** □ Dizziness □ Tingling □ Difficulty with balance □ Tremor □ Loss of consciousness □ Seizures □ Change in coordination	**PSYCHIATRIC** □ Change in memory □ Depression □ Anxiety □ Stress □ Suicidal thoughts □ Substance abuse
MEN'S HEALTH □ Difficulty initiating stream of urine □ Dribbling after urination □ Lump in groin □ Lump in testicle □ Penile discharge □ Pain or swelling in scrotum □ Erectile dysfunction	**WOMEN'S HEALTH** □ Breast lump, pain, or discharge □ Irregular periods □ Hot flashes □ Painful intercourse □ Vaginal bleeding between periods □ Vaginal discharge or itching	**PERIPHERAL VASUCLAR** □ Cold extremities □ Decreased sensation in hands or feet □ Decreased pulses □ Pain or cramping in legs □ Painful extremities □ Ulceration of feet □	**COMMENTS/OTHER:**