Jantz Family Practice

706 Cadet Court
Lebanon, TN 37087
P: 615-449-2472 F: 615-449-4709

Robert J. Jantz, M.D. | **Caroline Hendrick FNP-C** | **Nathan H. Marks FNP-C**

Phone: 615-449-2472
Fax: 615-449-4709

706 Cadet Court
Lebanon, TN 37087

Patient Demographics

Name: (First Middle Last): ____________________

Date of Birth: ____________________ SS#: ____________________

Address: ____________________

City: ____________________ State: ________ Zip: ______________

Phone: ____________________ Cell: ____________________ Work: ____________________

Email: ____________________

Contact me for appointments and test results via: ___ Email ___ Cell ___ Home

May we leave a message on your voicemail? ___Yes ___ No

Patient's Employer: ____________________ Phone: ____________________

Insured's Name: ____________________ Date of Birth: ____________________

Insured's Employer: ____________________ Phone: ____________________

Which Pharmacy do you prefer and its location? ____________________

What type of insurance do you have? ____________________

ID # ____________________ Group # ____________________

Please give insurance card and photo ID to receptionist upon arrival at each visit.

I hereby authorize direct payment of medical/surgical benefits to Jantz Family Practice for services rendered in person or under their supervision by my insurance carrier. I agree to be financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that I am also responsible for all collection and/or attorney fees should my account be turned over for collection.

Patient Signature ____________________

Guardian/ Legal Rep (if minor) ____________________

Signature of Guardian ____________________

Today's Date ____________________

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RELEASE OF HEALTH INFORMATION

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR HEALTH RECORDS UNDER THE PROTECTION OF FEDERAL LAW, TITLE 42, CFR CHAPTER 11 PART 11

Name: ____ Date of Birth: _____________________

SS#: ______________________________ Sex: _____________________________

I Authorize (Name, Address, and Phone Number)____

____

____

to release my health records or information concerning my health records to **Jantz Family Practice**
706 Cadet Court Lebanon, TN 37087. Phone 615-449-2472 Fax 615-449-4709

I specifically consent only to the release of information or health records pertaining to:

_ All records
_ History and Physical
_ Consult Reports
_ Operative Notes
_ Physicians Orders
_ Laboratory
_ Imaging Radiology
_ Nursing Notes
_ Demographics
_ Special Tests and Therapies
_ Progress Notes
_ Other (specify): ____

I understand that I may revoke this consent to release of information at any time; however, I also understand that any release which has been made prior to my revocation and which was made in issuance upon this authorization shall not constitute breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when records are received or 1 year after the date of signature. At this time, no express revocation shall be needed to terminate my consent: however, revocation consent at any other time must be provided in writing.

____ ________________________
Patient's signature Date

____ ________________________
Witness Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name: ____ Date of Birth: ________________________

I have received a copy of the **NOTICE OF PRIVACY PRACTICES.** I understand that **Jantz Family Practice** has the right to change the PRIVACY PRACTICES from time to time and that I may contact the office at any time to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES**.

Do you have a living will? ___ Yes ___ No   Date it was it last updated? __________________

Emergency Contact: ______________________________ Phone:________________________

Who may receive information regarding your Protected Health Information?

(Test Results/Appointments/Balances/Account Information)

Name: ____

Check One: ___ Spouse ___ Child ___ Parent ___ Guardian ___ Friend ___ Other

Name: ____

Check One: ___ Spouse ___ Child ___ Parent ___ Guardian ___ Friend ___ Other

Name: ____

Check One: ___ Spouse ___ Child ___ Parent ___ Guardian ___ Friend ___ Other

Patient Signature ____

Guardian/ Legal Rep (if minor) ____

Signature of Guardian ____

Date _______________________________

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Patient Name:____ Date of Birth: ___________________

PATENT MEDICAL HISTORY (Please Check all that apply to your health history)

Allergies, Asthma		Diabetes	
Anemia		Arthritis	
Bleeding Disorders/Tendencies		Gout	
Heart Trouble		Peptic Ulcer	
High Blood Pressure		Kidney Problem	
Stroke		Alcohol or Drug Problem	
Cancer		Emotional Problem	
Glaucoma		Other:	

PATIENT SURGICAL HISTORY (Please check all that apply to your health history)

Mastectomy *Check one: _____ Both _____ Right _____ Left Breast	Date	Tonsillectomy	Date
___ Appendectomy	Date	Other Surgery	Date
Hysterectomy: *Check one: ___ Cervix ___ Uterus ___ Fallopian tubes ___ ovaries ___ Unknown	Date	Other Surgery	Date
Vasectomy	Date	Other Surgery	Date

PLEASE LIST ANY OTHER HOSPITALIZATIONS:

Reason:____ Date:_____________________________
Reason:____ Date:_____________________________

FAMILY MEDICAL HISTORY (Please check any that apply)

MEDICAL HISTORY	RELATIONSHIP TO YOU (MOTHER, FATHER, ETC)	DECEASED	IF YES AGE AT DEATH
Anemia			
Bleeding Tendencies			
Heart Trouble			
High Blood Pressure			
Stroke			
Cancer (Type)			
Glaucoma			
Diabetes			
Arthritis			
Gout			
Peptic Ulcer			
Kidney or Bladder Problem			
Alcohol or Drug Problem			
Emotional Problem/Nervous Breakdown			

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Patient Name:____ Date of Birth: ___________________

PATIENT ALLERGIES: (Please list any allergies to medications below)

____
____
____
____
____

PATIENT MEDICATIONS: Please list any Prescription or Over the Counter medications below:

MEDICATION NAME	STRENGTH	DOSE

SOCIAL HISTORY/HABITS: Check all that apply

Tobacco ____ Cigarettes ____ Pipes ____ Cigars Amount per day _________

# of Years ______ Have you quit? ____ Yes ____ No

Alcoholic Beverages: Occasionally ____ Daily ____ Weekends ____ Never________

Type ____________________________ Amount __________

Coffee/Caffeine Cups/Glasses per Day ______________

Exercise: ____Yes ___No

Type__________________________ Times per week __________