Signature Health & Wellness

Moses A. Swauncy, MD Lorrie Richardson, FNP-C

Today's Date: _____

Patient Name:_____ **DOB:** _____ **Gender:** **M** **F**

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Social Security #** _____

Marital Status: Single/Married/Divorced/ Widow(er) Phone #: _____ **Alternate #:** _____

Email Address: _____ **Can we send you emails?** ____ **YES or** ____ **NO**

How did you hear about us? _____

Employer/School: _____ **Phone #:** _____

Address: _____ **Occupation:** _____

Primary Insurance:

Subscriber's Name (as it appears on card): _____

Subscriber's DOB: _____ **Subscriber's Social Security #:**

_____

Relation to patient (if other than self): _____ **Subscriber's Employer:** _____

Responsible party for minor child:

Name: _____ **DOB** _____ **Relation to child:** _____

Social Security # _____ **Phone #** _____ **Alternate:** _____

Emergency Contact:

Name: _____ **Relation to patient:** _____

Phone #: _____ **Alternate #:** _____

- Social Security Authorization: I certify that the information given me in applying for payment under the title XIX of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for claims made for Medicare, Medicaid, or other third party payments. I request that payments of authorized benefits be made directly to Signature Health & Wellness or its agent on my behalf.
- I hereby authorize Signature Health & Wellness to examine me and render treatment as deemed necessary.
- I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature: _____ **Date:** _____

6001 Jackson Square Blvd., Ste 100
LaVergne, TN 37086
Phone: 615-793-9900
Fax 615-793-9990

NAME: _____ **ALLERGIES:** _____

PLEASE LIST MEDICATIONS BELOW

Past surgical history: _____

_____

_____

PLEASE CHECK THE FOLLOWING:

DISEASE	YOU	FAMILY MEMBER	DISEASE	YOU	FAMILY MEMBER
Heart Attack			Stroke		
Emphysema			Bleeding Disorder		
Cancer			Diabetes		
Tuberculosis			Thyroid Disorder		
Kidney Disorder			Liver Disorder		
Mental Health			High Blood Pressure		
High Cholesterol			**Females Only:**	**Number of:**	
Prostate Problem			Pregnancies		
Skin Disorder			Premature Births		
Headaches			Abortions		
Stomach Disorder			Ectopic		
Colon Disorder			Miscarriages		
Tobacco Use			Multiple Births		
Asthma			Living Children		

LIVING WILL/ADVANCE DIRECTIVE: ___YES ____NO

IMMUNIZATIONS: UP-TO-DATE _____ YES _____ NO DO WE HAVE A COPY? _____ YES _____ NO

LAST TETANUS SHOT: _____ **FLU SHOT:** _____ **PNEUMONIA SHOT:** _____

LAST EYE EXAM: _____

Signature Health & Wellness

Moses A. Swauncy, MD Lorrie Richardson, FNP-C

Authorization for Release of Medical Records

I hereby authorize:

Physician/Facility Name: _____

Address: _____

Phone #: _____ Fax #: _____

To release any and all medicals records including information regarding alcohol/drug abuse, lab results, radiology, progress notes, psychiatric, etc... To: (please check which location)

Signature Health & Wellness

6001 Jackson Square Blvd., Ste 100
LaVergne, TN 37086
Phone: 615-793-9900
Fax 615-793-9990

Patient Name: _____ DOB: _____

I understand that I may revoke this authorization at any time, unless an earlier date is specified. This authorization will automatically expire 12 months after the date signed below.

Signature: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add Columns _____ + _____ + _____

TOTAL _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of the things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Signature Health & Wellness

Moses A. Swauncy, MD Lorrie Richardson, FNP-C

Patient Name: _____ DOB: _____

Please check "yes" or "no" to indicate whether or not you are having any of the following signs/symptoms:		
	YES	NO
Fever/chills		
Shortness of breath		
Cough		
Chest pain or pressure		
Palpitations		
Nausea, vomiting, diarrhea		
Constipation		
Heat/cold intolerance		
Abnormal bleeding/bruising		
Burning with urination		
Feelings of depression or anxiety		
Rash		
Headache		
Dizziness		
Numbness/tingling		

Please answer the following questions by checking "yes" or "no":		
	YES	NO
1. Have you felt you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

6001 Jackson Square Blvd., Ste 100
LaVergne, TN 37086
Phone: 615-793-9900
Fax 615-793-9990