DATE: **CHART #**

Patients Name	Date of Birth	Age	Marital Status	E-Mail address
Street Address	City	State	Zip	Home Phone
Your Employer	Your Occupation	Length of Employment		Your Cell number
Employer Address	City	State	Zip	Work Phone Number
Spouse/Guarantor Name	Spouse/Guarantor Employer	Length of Empl.		Work Phone Number
Name of Insurance Company	Policy Number	May we leave a message for you to return our call at your? Home: - Yes ☐ No ☐ E-mail - Yes ☐ No ☐ Text Work: - Yes ☐ No ☐ Cell: - Yes ☐ No ☐ Yes ☐ No ☐		
Your Social Security Number	Spouse/Guarantor Name	Social Security #	Date of birth	
Whom may we share information with	Whom may we not share information with			
Emergency Name /relationship	Phone Number			
Family Physician	Referred by			

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE CARRIER PAYMENTS. **THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGUARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR ALL SERVICES OR CO-PAYS WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.** ***YOU WILL BE BILLED SEPERATELY BY THE PATHOLOGIST OR LABORATORY FOR BLOOD WORK AND CULTURES.***

Signature _____ Date _____

INSURANCE AUTHORIZATION ASSIGNMENT

I hereby authorize Dr. Vick to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered to my dependents and myself. *I understand that I am responsible for any amount not covered by insurance and agree to follow the financial policy.*

Signature _____ Date _____

George W. Vick, II, M.D., F.A.C.O.G.
Amy Brackins, A.P.R.N, B.C., M.S.N.
501 19th Street Suite 304
Knoxville, TN 37916
865-522-2229

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GEORGE W. VICK, II, M.D.
F.A.C.O.G.

AMY BRACKINS, A.P.R.N., B.C.,
M.S.N.

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by George W. Vick II, M.D. P.C., Amy Brackins A.P.R.N., B.C., M.S.N., employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the physician.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or nurse practitioner.

I acknowledge that I have received a copy of the Notice of Privacy Practices and I understand that the notice is also posted where services are provided.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient here. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient's Signature Patient's Name (printed)

_____ _____

Witness Date

Patient, _____, is a minor, or is unable to sign above because:_____

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date

HISTORY AND PHYSICAL

Name: _____ SS# _____ Date: _____

Address: _____ Occupation: _____

Phone: _____ (Work) _____ Birth Date _____

Chief Complaint: _____

DRUG ALLERGIES

_____

_____

_____

CURRENT MEDS

_____

_____

_____

FAMILY HISTORY

LAST UPDATE

Disease	Self	Father	Mother	Fathers Parents	Mothers Parents	Siblings
Cancer (specify type)						
Diabetes						
Emphysema						
Asthma						
Arthritis						
Anemia						
High blood pressure						
Hepatitis						
Birth Defects						
Twins/Triplets						
Free Bleeding						
Blood Clotting Problems						
Cystic Fibrosis						
Thyroid disease						
Heart Attacks						
Strokes						
TB						
Seizures						
Rheumatic Fever						
Colitis						
Hiatal Hernia						
Drug/Alcohol						
HIV						
Ulcers						
Kidney Disease						
Hysterectomy						
Psychiatric						

Is there any other condition that you think we should be aware of? _____

_____

Physician Initials _____

George W. Vick II, MD., F.A.C.O.G

Amy Brackins A.P.R.N., B.C, M.S.N.

FEMALE HISTORY:

Age of your first period _____

Current number of days of flow_____

Number of days for each monthly cycle _____

First day of last period _____

SOCIAL HISTORY

1. List number of marriages _____
2. Date of last marriage _____
3. Age of husband _____
4. Religious Preference _____
5. Smoke _____ Packs Daily _____
6. Alcohol _____ Intake _____
7. Exercise _____ How often _____
8. Caffeine _____ Intake _____

PHARMACY NAME: _____

Phone Number: _____

BIRTH CONTROL USAGE

Previous form:

_____ Condoms _____ Pills

_____ Inserts _____ IUD

_____ Abstain _____ Implant

_____ Withdrawal _____ Diaphram

_____ Depo Provera _____ None

List Current Method _____

_____

BIRTH CONTROL PILLS USAGE

Name and date on pills

_____

_____

Problems:

_____ Headaches _____ Swelling

_____ Nausea _____ Weight Gain

_____ Irregular bleeding _____ No periods

PREGNANCIES:

If none check here ☐

Date	Sex	Baby's Wgt.	Lgth. Of Labor	Type of Anesth.	Child's Name	Delivering Doctor	Complications
1.							
2.							
3.							
4.							
5.							

OPERATIONS:

If none check here ☐

Date	Type	Surgeon	Problems or Complications
1.			
2.			
3.			
4.			
5.			

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Amy Brackins A.P.R.N., B.C., M.S.N.