LeConte Pulmonary & Critical Care Medicine
744 Middle Creek Rd, Suite 208
Sevierville, TN 37862
Phone (865) 446-9725
Fax (865) 446-9726

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address				Work Phone #		

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES_____NO_____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

Covenant HEALTH

ACCOUNT NUMBER: _____

PROVIDER AUTHORIZED TO RELEASE HEALTH INFORMATION (check all that apply):

☐Claiborne Medical Center ☐Cumberland Medical Center ☐Ft. Loudoun Medical Center ☐Ft Sanders Regional Medical Center
☐LeConte Medical Center ☐Methodist Medical Center ☐Morristown Hamblen Health System ☐Parkwest Medical Center
☐Peninsula Behavioral Health ☐Roane Medical Center ☐Thompson Cancer Survival Center ☐Covenant Home Care
☑ Other: LeConte Pulmonary and Critical Care: Pam Wright DNP, Brandon Brown NP,and Dr. William Cole
☐ PENINSULA OUTPATIENT CLINICS: ☐ Blount ☐ Knoxville ☐ Loudoun ☐ Sevier ☐ IOP ☐ WIT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Birth: ___/___/_____ **Date of Death, if applicable:** ___/___/_____ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

The information is to be disclosed to the following persons or organizations (Self or Authorized Receiving Party):

Name/Title: LPCC- Wright Brown Cole Phone: 865-446-9725 Fax: 865-446-9726
Address: 744 Middle Creek Rd Suite 208 City: Sevierville State: TN Zip: 37862

Purpose: ☐At the request of patient ☐ Legal Purposes ☑Other: to continue care

INFORMATION TO BE DISCLOSED includes dates of service from _____ to _____

☐ **Entire medical record**

OR

☐ Discharge Summary	☐ Progress Notes	**PENINSULA SPECIFIC:**
☐ History and Physical Exam	☐ EKG/s	☐ Assessment(s)
☐ Consultation Report/s	☐ Photographs, videotapes, or other image	☐ Treatment(s)/Therapies
☐ Operative Report	☐ HIV Test Results and Treatment	☐ Substance Use Disorder
☐ Pathology Report	☐ Mental or Behavioral Health	**OTHER:**
☐ Emergency Room Record	☐ Physical/Occupational/Speech Therapy	
☐ Lab Results	☐ Cardiac Rehabilitation	
☐ Radiology Report/s	☐ Implant Records	

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: 1) One year after the date this authorization is signed **or** 2) On the occurrence of the following event: _____.

I understand I may revoke this authorization at any time by sending a written notice to each provider marked above. Revocation will not affect any uses or disclosures provider(s) may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that there may be a reasonable copying fee, as permitted by applicable law.

SIGNATURE _____ **DATE** ___/___/___ **TIME** _____

If signed by patient's legal representative please complete the following and attach appropriate documentation

Printed Name: _____ **Relationship:** _____

FOR PROVIDER USE ONLY

How was identity verified? _____ Copy made? ☐ Yes ☐ No
How was authority verified? _____ Copy made? ☐ Yes ☐ No
By: _____ Title: _____ Date: _____
☐ Picked up ☐ Mailed ☐ Faxed Date: ___/___/_____ Released by: _____

health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is provided at https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, *please check one of the following*:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____
Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE _____ TIME _____ AM/PM

A copy of this agreement will be provided on request.

LeConte Pulmonary & Critical Care

Pamela F. Wright DNP
Brandon D. Brown NP-C

Patient Name:_____ Date:_____

Briefly describe you present symptoms:_____

_____

Personal Health History:

Arthritis	High Blood Pressure	Thyroid Disease	Rheumatic Fever
Broken Bones	Heart Murmur	Kidney Disease	Kidney Stones
Asthma	Stroke	Hepatitis (yellow jaundice)	Meningitis
Emphysema	Epilepsy	Gallstones	Polio
COPD	DVT	Pulmonary Embolism	Anemia
Pneumonia	Migraines	Tuberculosis	Hay Fever
Allergies	Stomach Ulcers	Bleeding tendency	Hives
Blood Transfusions	Heart Disease	Depression	Diabetes
Colitis or Bowel Disease	Emotional Problems	Peripheral Vascular Disease	
Bird Exposures (at home/work)		Blood Clots (Where?_____	
Cancer- (what kind?) _____		When?_____	
Chemo? [] Yes [] NO When?_____		Radiation? [] Yes [] No When? _____	

Surgeries:

Date:	Procedure:	Vaccination:	Date:
		TB Skin Test	
		Influenza	
		Pneumovax	
		Prevnar13	

LeConte Pulmonary & Critical Care

Pamela F. Wright DNP
Brandon D. Brown NP-C

Patient Name:_____ Date:_____

Occupational Exposures:

Fume Or Dust:(Asbestos, Plastic, Welding Fumes Glass, Wood, Sand Grain, Hay)	How Long?	When Was last exposure?
Metals: (Arsenic,Cadmium,Lead, Mercury,Nickel)		
Solvents: (Alcohols,Gasoline,Benzen,Toluene,Xylene, Carbon,Tetracholride,Paint,Varnish)		
Chemicals: (Pesticides,herbicides,Acids,Alkali,Ammonia, Dyes, Formaldehyde		
Body Fluids: (Human Tissue,Blood Samples,Body Fluid)		
Radiation:		
Other- What Kind?		

Current Job_____Past Jobs_____

Birthplace_____States/Places you have lived_____
Traveled out of the country: When and Where?_____
Tobacco: Do you Currently smoke? [] Yes [] No Have you ever smoked []Yes [] No
If yes, what? [] Cigarettes [] Pipes []Cigars [] E-Cigs [] Vapor
How much (Circle One)?_____ Cigarettes/Packs/Cartridges per day
How long have you smoked?_____ Years
If no, When did you quit?_____Age How long did you smoke?_____Years
Do you chew tobacco? []Yes [] No Have you ever chewed tobacco? [] Yes [] No

Caffeine: Do you drink caffeine? []Yes [] No If yes, What? [] Caffeine [] Tea [] Soda
How much per day?_____ Cups per day?(coffee, tea) _____ Ounces per day (Soda)

Weight: Now_____ 1 Yr Ago _____ Desired _____

Alcohol: Do you drink alcohol? [] Yes [] No What kind?_____
How many per day/week/month (circle one)_____
Have you ever been told you have a drinking problem? [] Yes [] No

Exercise: Do you exercise regularly? [] Yes []No Any shortness of breath? [] Yes [] No
What type of exercise/activity causes shortness of breath?_____

LeConte Pulmonary & Critical Care

Pamela F. Wright
Brandon D. Brown

Family History (Immediate Family Only):

	Age	Health	Age At Death	Cause Of Death
Father				
Mother				
Brother/Sister				
1.				
2.				
3.				
4.				
5.				

Has any blood relative ever had?	Who?	Other (List condition below)	Who?
Arthritis			
Asthma			
Birth Defects			
Cancer (if yes, what kind)			
Cystic Fibrosis			
Diabetes			
Epilepsy			
Heart Disease			
Migraines			
Substance Abuse			
Kidney Disease			
Bleeding Tendancy			
Thyroid Disease			
Tuberculosis			

REVIEW OF SYSTEMS (Please Circle Yes or No)

GENERAL

Weight Change >10lbs	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Difficulty Sleeping	YES	NO

HEAD AND NECK

Dizziness	YES	NO
Sinus Problems	YES	NO
Hoarseness	YES	NO
Persistant Sore Throat	YES	NO

RESPIRATORY/LUNGS

Stop breathing during sleep	YES	NO
Shortness of breath	YES	NO
Coughing up blood	YES	NO
Wheezing	YES	NO
Cough	YES	NO
Sore Throat	YES	NO
Snoring	YES	NO

SKELETAL

Joint Swelling/Stiffness	YES	NO

HEART/VASCULAR

Chest pain/tightness	YES	NO
Smothering feeling at night	YES	NO
Ankle Swelling	YES	NO
Palpitations	YES	NO
Passing out	YES	NO

NEURO

Severe frequent headaches	YES	NO

STOMACH/BOWEL

Frequent heart burn/acid(GERD)	YES	NO
Difficulty Swallowing	YES	NO

SKIN

Persistent rash	YES	NO

KIDNEY/BLADDER

Urinary retention	YES	NO

PSYCH/SOCIAL

Depression	YES	NO

Home Medication

Pharmacy Name/Location:_____ **Pharmacy Phone #:**_____

Medication Allergies:
[] NO Allergies:

Medication	Reaction (Hives, Itching, Anaphylasix, ect)

Current Medication: (Including OTC/Herbals):
[] NO Home Medications:

Drug Name:	Dose (MG)	Frequency (How often do you take this?)