IM

Scales Nutrition and Wellness Center

Patient Registration

Patient's Last Name

Patient's First Name MI

Address Apartment No.

City, State, Zip Code

Home Phone Cell Phone

Email

Date of Birth Social Security

Sex (Please Circle)
Male Female

Marital Status (Please Circle)
Married Single
Divorced Widowed

Driver's License Number State

Name of Employer Phone No.

Name of Emergency Contact Phone No.

Referring Physician (if applicable):

Spouse/Parent (Please circle)

Name

Address

City, State, Zip Code

Phone Number

Insurance Information

Primary Insurance

Name of Insurance Carrier

ID Number Group Number

Secondary Insurance

Name of Secondary Insurance

ID Number Group Number

Privacy Practices (Please Initial Each Line)

_______ I acknowledge that Dr. Scales office personnel has given me a copy of their Notice of Privacy Practices. I authorize Dr. Scales and/or his office personnel to communicate with family, friends, or other health care providers as to my medical conditions. Listed below are the (specific) family members or health care providers to who I give permission to discuss my health status. ____________________

_______The following listed names are (specific) family members or health care providers with whom I Do Not want my medical conditions discussed. ____________________

_______ I authorize Dr. Scales or his office personnel to leave messages on my voice mail at home and work, or email.

_______ I authorize other physicians or health care providers I have seen to exchange medical information with Dr. Scales, unless otherwise indicated.____________________

Financial & Insurance Policy (Please Initial Each Line)

_______ I hereby authorize payment of benefits processed on by behalf to Scales Nutrition & Wellness Center for any services furnished to me by Dr. Scales. Furthermore, I authorize Dr. Scales and his office personnel to release any information obtained in the course of my evaluation & treatment to permit processing of claims for insurance reimbursement. I understand I am responsible for payment of any service(s) my insurance does not pay or process in a timely matter, customarily in 60 days.

_______ I understand I am financially responsible for paying my co-payments, co-insurance, deductibles and all outstanding balances. In the event that any past due balance is placed with a third party, I agree to pay any cost of such collection including the agency fees, legal/attorney fees and court cost.

_______I understand if I cancel my appointment within 24 hours of the scheduled appointment or fail to keep a scheduled appointment, I will be charged and responsible for paying twenty-five ($25) dollars for an internal medicine & medication management appointment, seventy ($70) dollars for a psychiatry appointment, fifty ($50) dollars for a therapy appointment, and appropriate charge(s) for a missed nutrition appointment.

Signature of Patient (Parent or guardian if patient is a minor) Date

Scales Nutrition and Wellness Center

1010 Fourth Avenue North, Nashville, TN 37219 (615) 724-0865

Your rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You may have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (615) 724-0865.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name________________________ Signature________________________ Date________

Scales Nutrition and Wellness Center
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Date:________________________

Name:________________________________ Age:________

Occupation:____________________________ Marital Status: M S D W

Please indicate if you have suffered any of the following:

☐ Asthma	☐ Jaundice	☐ Heart Attack	☐ Stroke
☐ Arthritis	☐ Gout	☐ Heart Murmur	☐ Tuberculosis
☐ Bladder Infections	☐ Goiter	☐ Hernia	☐ Ulcer
☐ Diabetes	☐ Glaucoma	☐ High Blood Pressure	☐ Cancer
☐ Epilepsy	☐ Hay Fever	☐ Rheumatic Fever	☐ Psychiatric Disorder

Other Medical Problems not noted above:____

____

List any Hospitalizations for illness, trauma, or surgery below, please give reason and date of hospitalization:

DATE:	Reason for Hospitalization:

Medications: Please list all medications including over the counter medications, antacids, laxatives, birth control pills, vitamins, herbs, etc.

Drug	Dose	How many times per day?	Length of time taken

Allergies: Are you allergic to any medications, latex, or foods? If so, Please list them and the problem that you experienced.

Medication/Food Allergy	Problem Experienced

Name________________________________ Date______________________

Vaccinations within the past ten years (please include date it was given):

Tetanus (TT, Td, or DPT)___________
Pneumovax: ______________________
Influenza: ______________________
MMR: ___________________________
Hepatitis B: ______________________
HIB: ___________________________

Health Maintenance Date (include dates if known):

PPD (for TB)_____________________
Hemoccult: ______________________
Mammography: __________________
Stress Test: ______________________
Chest X-ray: _____________________
Flexible Sig/Colonoscopy:__________
Pap Smear/PSA: ___________________
Breast/Testes: ____________________
EKG: ____________________________
Echocardiogram: __________________

Personal Health Habits:

Do you smoke?	Y	N	How many years?________________
Have you ever smoked?	Y	N	How many years? _______________
			How many packs per day? __________
Do you drink alcohol?	Y	N	How many drinks per week?
			Date of last drink: _______________
Do you exercise regularly?	Y	N	What kind of exercise?____________
			How often?______________________
Do you use recreational drugs?	Y	N	What kind?______________________
			How often?______________________
Do you have any problems sleeping?	Y	N	How many hours nightly?___________
Do you follow a special diet?	Y	N	What kind?_______________________
Have you ever been exposed to Toxins or fumes at home/work?	Y	N	What kind?_______________________

Review of Symptoms:

Have you had any of the following problems? If so, which ones and when did they start?

General:	No	Yes	When/Explain
Skin/rash	___	___	______________________
Bruise easily	___	___	______________________
Joints ever painful?	___	___	______________________
Lost or Gained weight?	___	___	______________________
Sensitive to Heat/Cold	___	___	______________________
Head and Neck			
Frequent Headaches	___	___	______________________
Frequent Cold's	___	___	______________________
Problems with Vision	___	___	______________________
Hearing	___	___	______________________
Frequent Nosebleeds	___	___	______________________
Hair Loss	___	___	______________________
Difficulty Seeing at Night	___	___	______________________
Taste Alteration	___	___	______________________
Bleeding Gums	___	___	______________________
Dry Mouth	___	___	______________________
Sores in Mouth	___	___	______________________

Name: ______________________________ Date: ____________________

Scales Nutrition and Wellness Center

Chest and Cardiovascular	No	Yes	When/Explain
Shortness of breath	___	___	___
Wheezing	___	___	___
Chest Discomfort	___	___	___
Extremities Cold/Numb	___	___	___
Swelling of Hands/Feet	___	___	___
Frequent Coughing	___	___	___
Coughing up Blood	___	___	___
Daytime Drowsiness	___	___	___
Loud snoring	___	___	___
Unrested after Sleep	___	___	___
Gastrointestinal			
Stomach Pains	___	___	___
Frequent Nausea	___	___	___
Frequent Constipation	___	___	___
Black Stools	___	___	___
Blood or Pus in Stool	___	___	___
Vomiting Blood	___	___	___
Frequent Diarrhea	___	___	___
Trouble Digesting food	___	___	___
Frequent Laxative Use	___	___	___
Genitourinary			
Urinate >1 time/night	___	___	___
Urinate >6 times/day	___	___	___
Burning during urination	___	___	___
Urine Brown or Bloody	___	___	___
Sexual Difficulties	___	___	___
Musuloskeletal			
Knee Problems	___	___	___
Back Problems	___	___	___
Leg Cramps	___	___	___
Joint Pain	___	___	___
Change in Mobility	___	___	___
Neurological			
Dizziness	___	___	___
Memory Loss	___	___	___
Tremors	___	___	___
Seizures	___	___	___
Headaches/Migraines	___	___	___

Name: ______________________________ Date: ______________________________

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Reproductive History (*For Women Only*):
At what age did you first menstruate?________________________________
When was your last menstrual period? ________________________________
Number of live births?________________________________
Number of Miscarriages or Stillbirths? ________________________________
Number of Abortions?________________________________
Do you take oral contraceptives or have an IUD?________________________________
Do you have a problem with Vaginal Discharge?________________________________
Do you have trouble holding your urine when you sneeze/cough?________________
Do you do self breast examinations?________________________________

(For Men Only):

Have you ever had prostate trouble?	Y	N
Has your urine stream become weak or slow?	Y	N
Have you had pain, swelling, or lumps in your testicles?	Y	N
Do you have any children?	Y	N

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma						
Heart Disease						
Hypertension						
Rheumatic Fever						
Stroke						
Cancer						
Obesity						
Depression/Mental Illness						
Liver Disease						
Diabetes						
Kidney Disease						
Arthritis						
Sleep Apnea						
High Cholesterol						
Bleeding Disorder						
Epilepsy						

Name: ________________________________ Date: ________________________________