WOODBURY MEDICAL CENTER

Jeffrey L. Todd, MD
Paula M. Todd, DNP, FNP
Rachel Caldwell, FNP
Monika Safarpour, FNP
Abigail Jones, PA

205 South McCrary Street
Woodbury, TN 37190
Phone: (615) 563-2891
Fax: (615) 563-4582

Date:	How did you hear about our office?	
Patient Full Name:		
DOB:	Social Security Number: - -	
Address:		
City:	State:	Zip:
Home Phone:	Cell/Alternate:	
Do you prefer calls or texts for appointment reminders? ☐ Calls ☐ Texts		
May we leave information on your voicemail? ☐ Yes ☐ No		
Sex: ☐ Male ☐ Female	Race:	
Preferred Language:	Ethnicity:	
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single		
Employer Name & Address:		Employer Phone:
Pharmacy Name & Address:		Pharmacy Phone:
Who may we speak to regarding your personal health information?		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
In the event of an emergency please contact:		
Name:	Relationship:	Phone:
Alternate phone:		
Would you like to receive results and have the ability to communicate with your provider or practitioner through our secure patient portal? ☐ Yes ☐ No		
Email Address:		

BILLING INFORMATION: Who will pay for services NOT covered by insurance?	
Name:	Relationship to patient:
Address:	
Date of Birth:	Social Security Number:
Phone number:	Alternate Number:
HIPPA ACKNOWLEDGEMENT	
Patient's Name:	DOB:
☐ Taken a HIPPA Notice of Privacy Practices for my records.	
☐ I have been offered a Notice of Practices but declined.	
Patient Signature:	
Date signed:	
INSURANCE INFORMATION (Please provide all insurance cards to receptionist for copies)	
Primary Insurance Company Name:	
Member ID:	Group Number:
Insured's Name:	Insured's DOB:
Insured's Employer:	Insured's SSN:
Relationship to patient: ☐ Self ☐ Spouse ☐ Child	
Secondary Insurance Company Name:	
Member ID:	Group Number:
Insured's Name:	Insured's DOB:
Insured's Employer:	Insured's SSN:
Relationship to patient: ☐ Self ☐ Spouse ☐ Child	
I hereby authorize release of any information, including the diagnosis and record of any treatment or examination rendered to me or my dependent, during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me, directly to Woodbury Medical Center. I understand that my insurance carrier my pay less than the actual bill for my services. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF OR MY DEPENDENT. THERE IS A $25 FEE FOR ALL MISSED APPOINTMENTS.	
Patient's Signature (Or Legal Guardian if under 18)	
Date:	

Woodbury Medical Center: Health Questionnaire

Patient Name:	DOB:	Sex:

Information is self-reported by Patient or Patient/Guardian. State name of person completing form and relationship to patient:	
GENERAL HEALTH/SAFETY QUESTIONS (Check all that apply)	
Primary language of family members/guardian: ( ) English ( ) Spanish ( ) Other:	
Ethnicity:	Marital Status:
Highest Grade Completed: College:	
( ) Public Water Supply ( ) Other Water Supply ( ) Guns in Home ( ) Physical/Sexual Abuse ( ) Wear Seat Belt/Car Seat ( ) Smoke Detectors in Home ( ) Regular Exercise	
Allergies:	

TOBACCO USE	
( ) Smoke Cigarettes	Packs per day:
( ) Past Smoker	Date Stopped:
( ) Chews/Dip	Frequency:
( ) Past Chew/Dip	Date Stopped:
( ) What year did you start smoking?	Date:
( ) Exposure to 2nd Hand Smoke	Where? (ex. Car, house)
( ) Electronic cigarette/Vape	How much per day?

SUBSTANCE ABUSE		
( ) Alcohol	Type:	How much/how often:
( ) Drugs (street/recreational/IV)	Type:	How much/how often:

VACCINE HISTORY (Please enter the date you last received each vaccine)			
Influenza	Date:		
Pneumonia	Prevnar 13 Last Date:	Pneumovax 23 Date:	Prevnar 20 Date:
Shingles	Zostavax Date:	Shingrix 1 Date:	Shingrix 2 Date:
Tetanus	Date:		
MMR	Date:		
COVID	Date(s):		

PERSONAL MEDICAL HISTORY (Please check all that apply)		
( ) Anemia	( ) Seizures	( ) Migraines
( ) Arthritis	( ) Gallbladder	( ) Sexually Transmitted Infection
( ) Asthma	( ) Hearing Impaired	( ) Shingles
( ) Blood Clots	( ) Heart Disease	( ) Skin Problems
( ) Cancer	( ) Heart Attack	( ) Stroke
( ) Colon problems	( ) HIV/AIDS	( ) TB (Tuberculosis)
( ) COPD	( ) Kidney Disease	( ) High Blood Pressure
( ) Depression	( ) Bladder problems	( ) Physical Activity Limitation
( ) Diabetes	( ) Liver Disease/ Hepatitis	( ) Mental Illness

Woodbury Medical Center: Health Questionnaire

Patient Name:	DOB:	Sex:

Childhood Diseases:
Hospitalizations (other than surgeries):
Surgeries:
Other injuries:
Specialists you see:
Last Colon Cancer Screening:

FAMILY MEDICAL HISTORY (Please check all that apply)

Diagnosis	Type	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Cancer						
Diabetes						
High Blood Pressure						
Heart Disease/Attack						
High Cholesterol						
Stroke						
Kidney Disease						
Glaucoma						
Bleeding Disorder						
Mental Illness						
Seizure Disorder						
Other						

FOR CHILDREN UNDER 6 YEARS OF AGE				
Birth Weight:	Birth Length:	( ) Vaginal Birth	( ) C-Section	( ) Premature (<36 weeks)
Pregnancy Complications:				
Delivery Complications:				
Hospital of Birth:				
Daycare:				

FOR WOMEN ONLY			
Last Period Date:	# of Pregnancies:	# of Live births:	Date of last Delivery:
Last Mammogram Date:	History of abnormal mammogram?	Last PAP Date:	History of abnormal PAP?

ADVANCE DIRECTIVES FOR HEALTHCARE	
Have you finalized any advance health directives (living will, durable power of attorney, organ donation, "do not resuscitate instructions")? ( ) Yes ( ) No	
Information given to Woodbury Medical Center? ( ) Yes ( ) No	
Patient Signature:	Date:

Annual Preventative Screening (For All Patients 18 and Older)

Name	DOB	Date

Please fill out this form entirely and return to your nurse or to the front office staff. Thank you.

Have you fallen in the last 12 months?	☐ Yes	☐ No
How many times have you fallen?	_____ times	
Were you injured when you fell?	☐ Yes	☐ No
Have you leaked any urine, even a small amount, in the past 6 months?	☐ Yes	☐ No
If yes, what are you currently doing to manage your bladder leakage?	Answer:	

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

Total Score (for office staff only): ☐

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

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

PROVIDER REVIEWED INITIALS: _____

***** PROVIDERS: DO NOT FORGET TO DOCUMENT POSTIVE OR NEGATIVE RESULT IN TODAY'S NOTE AS WELL AS FOLLOW-UP PLAN*****

Woodbury Medical Center
205 S. McCrary St. Woodbury, TN 37190
Phone: 615-563-2891 / Fax: 615-563-4582

Medication List

Name: DOB: Date:

Please list all the prescription and over the counter medications that you take.

Medication Name	Strength	Directions on bottle	Reason you take it
Example: Lisinopril	10mg	1 tablet once daily	High blood pressure

WOODBURY MEDICAL CENTER
Cannon County Healthcare, PC
205 SOUTH MCCRARY ST
WOODBURY, TN 37190
PHONE: (615) 563-2891
FAX: (615) 563-4582

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(ALL SECTIONS MUST BE COMPLETED)

Patient Name: _____DOB: _____

I hereby authorize the following practice and its physicians, employees and agents, to release or disclose to the below-named recipient all my medical records, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted infection, or HIV/AIDS infection.

REQUESTING RECORDS FROM: _____

Phone: _____ Fax: _____

I hereby authorize the release of medical records to the following healthcare provider:

☐ JEFFREY L. TODD, MD ☐ PAULA M. TODD, NP ☐ ABIGAIL JONES, PA-C
☐ RACHEL CALDWELL, NP ☐ MONIKA SAFARPOUR, NP

To be sent to the following fax number: **(615) 563-4582.**

Purpose of disclosure: ☐ CONTINUATION OF CARE ☐ TRANSITION OF CARE ☐ OTHER: _____

The authorization will expire on_____ (Date may not exceed one year)

This request and authorization apply to:

☐ All medical records
☐ Healthcare information relating to the following treatment, condition, or dates of treatment
_____

☐ Specific records to be released (labs, imaging reports, other)
_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you DO NOT WANT to be released.

☐ Substance abuse ☐ Psychological or psychiatric treatment ☐ HIV/AIDS/STI

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization, and the above-names office may not condition treatment on my signing of this authorization.

SIGN HERE _____ **Signature of Patient or Authorized Representative** _____ **Date signed**

_____
Relationship to patient

Woodbury Medical Center

205 S. McCrary Street, Woodbury, TN 37190

Ph: 615-563-2891 Fax: 615-563-4582

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NO SHOW/LATE CANCELLATION POLICY

ALL PATIENTS THAT DO NOT

CANCEL OR **RESCHEDULE** THEIR APPOINTMENTS

WITH AT LEAST A 24 HOUR NOTICE,

WILL BE CHARGED A $25 **"NO SHOW OR LATE CANCELLATION FEE".**

THIS WILL BE

APPLIED TO YOUR ACCOUNT.

THIS CHARGE IS NOT REIMBURSABLE BY YOUR

INSURANCE COMPANY. YOU WILL BE ABLE TO

RESCHEDULE, ONCE THIS HAS BEEN PAID IN FULL.

REPEAT "NO SHOW" APPOINTMENTS WILL RESULT IN A DISCHARGE FROM THIS PRACTICE.

Signature of Notice: _____ **Date:** _____