Woodbury Medical Center
205 South McCrary St.
Woodbury, TN 37190
Phone: (615) 563-2891

Welcome!

Dear Valued Patient,

Hello and welcome to Woodbury Medical Center! We are honored that you chose us to be a part of your health journey!

At Woodbury Medical Center, we believe that great care starts with genuine connection. That's why we take the time to get to know you, listen to your concerns, and walk alongside you in every season of health. Our mission is simple: to treat every patient the way we would treat our own loved ones—with compassion and respect, and a deep commitment to your well-being.

From preventative checkups to chronic care management, we offer a wide range of services to meet your needs at every stage of life. Whether you are here for your annual wellness visit or just have a quick question, you can expect personalized care, thoughtful attention, and a team that truly cares.

We understand that life happens—and when it does, we are here for you. Instead of heading straight to an urgent care clinic or an emergency room, we encourage you to call us first. We offer same-day appointments for urgent concerns whenever possible, so you can get the care you need quickly from a team that knows your health history and truly cares about your long-term well-being.

Here's what you can expect as you get started:

- A care team that listens first and recommends with heart
- A comforting welcoming environment
- Easy access to appointments, including same-day availability for urgent needs
- A convenient patient portal to send messages, view test results, and manage your care
- An "after-hours" line for urgent care recommendation needs not within our regular office hours

Thank you for trusting us with your care. We are so glad you're here—and we look forward to caring for you and your family for years to come!

Sincerely,

Your Providers at Woodbury Medical Center
Jeffrey L. Todd, MD
Paula Todd, DNP, APRN-FNP-BC
Abigail Jones, PA-C
Sydney Hunt, FNP
Kody Sanderfer, NP

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:

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 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	( ) Vision Impaired	( ) Skin Problems
( ) Cancer	( ) Heart Disease	( ) Stroke
( ) Colon problems	( ) Heart Attack	( ) TB (Tuberculosis)
( ) Colon polyps	( ) HIV/AIDS	( ) High Blood Pressure
( ) COPD	( ) Kidney Disease	( ) High Cholesterol
( ) 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:

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

Annual Preventative Screening (For All Patients 18 and Older)

Name	DOB	Date

Please fill out this form entirely and return to your nurse or provider. 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:	
Do you want to talk to your provider about this today?	☐ Yes	☐ No

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**
If both answers above are "Not at all," do not continue. If either answer above is anything other than "Not at all," please continue below.				
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**

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

(For office staff use only) TOTAL SCORE: _____

Provider reviewed intials:

WOODBURY MEDICAL CENTER

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Phone: (615) 563-2891 Fax: (615) 563-4582
Jeffrey Todd, MD *Paula Todd, NP* *Abigail Jones, PA* *Sydney Hunt, NP* *Kody Sanderfer, NP*

Today's Date:	☐ New Patient ☐ Returning Patient
Patient's Full Name:	
DOB: / /	Social Security Number: - -
Address:	
City:	State: Zip:
Home Phone:	Cell/Alternate:
Do you prefer texts or calls for appointment reminders?	☐ Calls ☐ Texts
May we leave information on your voicemail?	☐ Yes ☐ No
Gender Assigned at Birth: ☐ Male ☐ Female	Race:
Preferred Language:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single	
Employer / School Name & Address:	Employer/ School 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:
THE SCREENINGS BELOW ARE <u>OPTIONAL</u>: ☐ *I do not wish to disclose the below information*	
Gender identity:	Pronouns:
Sexual Orientation: ☐ Straight / Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Other:	

BILLING INFORMATION: Who will pay for services NOT covered by insurance?

☐ *I, the patient, 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:

☐ I have 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 ☐ *All insurance cards have been given to receptionists*

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
205 S. McCrary Street
Woodbury, TN 37190

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 reschedule, once this has been paid in full.

Repeat "NO SHOW" appointments will result in a discharge from this practice.

Signature:_____

Date of birth:_____

Date:_____

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 Todd, MD ☐Paula Todd, NP ☐Abigail Jones, PA ☐Sydney Hunt, NP ☐ Kody Sanderfer, NP

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

Purpose of disclosure: ☐Continuity 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

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WOODBURY MEDICAL CENTER
VACCINE ADMINISTRATION

Woodbury Medical Center goes through a third-party company, VaxCare, to obtain vaccines to give to our patients.

Sometimes, this means VaxCare determines who we can administer vaccines to.

VaxCare's system lets us know if some vaccines are covered for you while you are in office. This also means that if VaxCare is out of network with your insurance, or cannot find your insurance coverage, that puts you at risk for receiving a bill for a non-covered vaccine.

If your insurance plan is out of network with our vaccine company, we will not administer this vaccine to you because you can obtain this at the pharmacy or health department without the risk of out-of-pocket cost or hidden fees.

As long as your insurance plan is in network with VaxCare flu and pneumonia vaccines are covered with all insurances. However, if you have a Medicare plan and your part D is not included in your primary Medicare plan, VaxCare cannot estimate the cost of some vaccines, such as Shingrix (shingles), Adacel (Tdap), and Abrysvo (RSV). This means we will ask you to seek that vaccine at the pharmacy or local health department.

VaxCare's patient hotline number is (888) 829-8550 if you have any questions about the coverage of vaccines with your specific health plan.

You are also always more than welcome to call or come to our office and speak to one of our medical assistants or nurses regarding your vaccines.

Thank you for trusting us with your care!