



7297 SPARTA PIKE • WATERTOWN, TENNESSEE 37184  
P: 615-237-0015 • F: 615-237-0021 • WWW.CVFAMILYCARE.COM

*Our Family... Caring for Yours.*  
Jim Cheeks, NP | Bruce McLaughlin, NP | Andrea Weddle, CNM, NP

**Patient**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female  
Maiden Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: M S D W  
Race: \_\_\_\_\_ / Declined Ethnic group: \_\_\_\_\_ / Declined Preferred Language: English / \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Preferred method of contact: (H) (W) (C) Email  
Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
Email address: \_\_\_\_\_ (review email communication agreement on back)  
Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**Employer Information:**

Patients Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Full time / Part Time / Student / Other  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Parent or Financially Responsible Party (if under 18) \*\*MUST HAVE PHOTO ID AVAILABLE\*\***

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_  
Address:  Same As Above / \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**Primary Insurance \*\*MUST PRESENT INSURANCE CARD\*\***

Insurance Name: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_ Cardholders Relationship to Patient \_\_\_\_\_  
First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance \*\*MUST PRESENT INSURANCE CARD\*\***

Insurance Name: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_ Cardholders Relationship to Patient \_\_\_\_\_  
First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a living will, durable power of attorney, or advanced directives?  
If No, would you like information?

Yes No  
Yes No

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**Insurance Information and Billing Practices:**

I authorize Mt. Juliet Family Care & Walk-in Clinic, LLC (MJFC) and Cherry Valley Family Care (CVFC) to furnish information to insurance carriers concerning my care. I agree to pay CVFC for all services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by my insurance and if I have not secured appropriate authorizations and otherwise complied with the terms of my benefit plan there may be a decrease or no coverage at all for services rendered at CVFC. For self-pay patients, I also understand that I am responsible for all services rendered to my dependants or myself.

*Full payment of Co-pays and self-pay charges are due the time of service.*

I understand that the responsible party will be assessed a fee as determined by Check Redi for all returned checks.

Any balance is ultimately my responsibility. In the event my balance is transferred to a collection agency or attempts are made to collect a delinquent balance using an outside source, I will be responsible for collection costs, attorney fees, and /or court cost up to and beyond the existing balance incurred.

I understand that if Workers' Compensation or another carrier is liable for my bills, my personal insurance is not responsible for payment. I understand that all insurance information must be given to CVFC before or at the time of service.

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**Consent to Treat & Medical Records Release Authorization:**

I authorize CVFC providers to provide treatment that they may deem advisable for my dependants and myself. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment.

I authorize CVFC to obtain any previous medical records, for my dependants or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependants or myself.

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**e-Communication Agreement**

This policy is intended for patients that have a password-protected email and is checked at least 2-3 times per week. CVFC will only communicate electronically with the approved email address you have provided. CVFC can be contacted via email through our website at [www.CVFamilyCare.com](http://www.CVFamilyCare.com). When requesting information please include your full name and birth date in the message to establish reasonableness that the sender requesting information is who the sender claims to be. The subject of the email should include the provider's name and the purpose of the email.

This office will use the provided email address to communicate directly with you. It will not be released to any third party other than for use of treatment, payment and healthcare operations. CVFC cannot and does not guarantee the privacy or security of any message sent over the internet. There is the potential that an email sent over the internet can be intercepted and read by others.

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**I have read the above items regarding insurance and financial responsibility, consent and medical records and e-communication and agree to the terms and conditions related to each item.**

\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_  
**Date**

**Patient Medical, Surgical, Social & Family History**

Date: \_\_\_\_\_ Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Medical History**

**Medication Allergies:** \_\_\_\_\_

**List all Current Medications** (prescriptions, OTC, or herbal remedies) \_\_\_\_\_

**Pharmacy:**  Watertown Drug  Webb (Alexandria)  
Lebanon Pharmacies:  Buckeye  CVS  Fred's  Gibbs  Kmart  Kroger  Publix  
 Rite Aid  Walgreens (S. Cumberland)  Walgreens (W. Main)  Walmart  
 **Other w/ phone number:** \_\_\_\_\_

**Patient Health History**  **No History of Illness**

- ADHD
- Allergies (Seasonal)
- Arthritis
- Asthma
- Bipolar
- Cancer (location: \_\_\_\_\_)
- Congestive Heart Failure
- COPD / Emphysema
- Crohn's
- Depression / Anxiety
- Diabetes
- Diverticulitis
- Fibromyalgia
- Gout
- Hearing Loss
- Heart Attack
- Heart Burn (acid reflux)
- High Blood Pressure
- High Cholesterol
- Hypothyroid
- Interstitial Cystitis
- Kidney Stones
- Mental Retardation
- Migraine Headaches
- Seizures
- Stomach Ulcers
- Stroke

**Health Maintenance:**

Date of Last Complete Physical: \_\_\_\_\_

Date of Last Bone Density: \_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_

**Women Only:**

Date of last Mammogram: \_\_\_\_\_

Date of last Pap: \_\_\_\_\_

**Other:** \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

**Patient Surgical History** (List below all past surgeries)  **No History of Surgeries**

- Appendix Removed
- Artificial Joints \_\_\_\_\_
- C-Section
- D & C
- Ear Tubes
- Gall Bladder Removed
- Hernia ( Left / Right )
- Hysterectomy ( Partial / Total )
- Mastectomy
- Pace Maker
- Pins or Plates inserted (location: \_\_\_\_\_)
- Spleen Removed
- Thyroid Removed
- Tonsils Removed
- Tubal Ligation

**Other:** \_\_\_\_\_

Date: \_\_\_\_\_ Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Family Health History**

**Father**

List any health problems: \_\_\_\_\_

No Known Health Problems     Has Died – Age and Cause of Death: \_\_\_\_\_

**Mother**

List any health problems: \_\_\_\_\_

No Known Health Problems     Has Died – Age and Cause of Death: \_\_\_\_\_

**Brothers**

How many \_\_\_\_\_

No Known Health Problems    List any health problems: \_\_\_\_\_

**Sisters**

How many \_\_\_\_\_

No Known Health Problems    List any health problems: \_\_\_\_\_

**Social History**

- Alcohol use?    Yes    No    Average amount - \_\_\_\_\_ /    Day    Week    Month    Year
- Smoke or Tobacco use?    Yes    No    How many Packs per day \_\_\_\_\_    Smokeless Tobacco?    Yes    No
- Caffeine (soda, tea, coffee)?    Yes    No    Average amount - \_\_\_\_\_ /    Day    Week    Month    Year.
- Recreational Drug Use    None / \_\_\_\_\_

Please describe any other information that you feel your health care provider should know: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason For Visit**

**Today:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of person documenting above medical history: (if other than patient): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



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The Health Insurance Portability and Accountability Act (HIPAA) requires CVFC to notify patients regarding how their Protected Health Information is handled. Our HIPAA policy is posted in the Lobby. You have the right to review the HIPAA policy and you may request a copy of the policy

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**\*With your permission, we may disclose your Protected Health Information to a family member, close friend or any other person that you identify below.**

I, \_\_\_\_\_, authorize CVFC to release any personal information relating to my health care

To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____

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I have reviewed the HIPAA Notice of Privacy Practices for CVFC. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: \_\_\_\_\_

Patients / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_