Welcome to University Trauma and Acute Care Surgeons

Office hours Monday through Friday 8:00 AM through 4:30 PM.

Please note that when the office is closed, urgent calls will be answered by the after-hours service.

In case of an emergency, please call 911 or go to nearest emergency room.

Appointment reminders:

- New patients please arrive 30 minutes early.
- Please bring photo ID, insurance cards, medication and allergy list to each appointment.

Late arrivals, reschedules, cancellations, and no-show policy:

- Please notify as soon as possible if you will be late or unable to keep your appointment time.
- Be advised if you are more than 15 minutes late and we are still able to see you, there may be a wait as you will be worked in.

Prescriptions and medication refills

- If you requested a medication refill, please allow 24-hour notice. Most refills can be sent electronically. If we can refill your medication, we will not return your call and will send it to your pharmacy. Please check with your pharmacy and if a prescription has not been received been the end of the business day, the day following your request, please call us back. Same day refills may not be possible. Please do not leave multiple messages as this will delay our response.

Test results, FMLA, and Medical Records

- Your results will be communicated to you by a clinical staff member or provider, a front office employee will not be able to review results with you.
- FMLA/ Short term disability paperwork will be completed within 7-10 business days. Please give specific details regarding duties and expected return to work date. You must sign a release for us to release your paperwork.

Patient name _____ Date of birth _____

Patient signature _____ Today's date _____

PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number
PATIENT INFORMATION		
Social Security #	Date of Birth	
First Name	Middle	Last Name
Home Address:	City:	State: Zip:
Home Phone ( )	Cell Phone ( )	Work Phone ( )
Email:	Race:	Ethnicity:
Gender (Circle as many as appropriate):		
Birth Sex: Male	Female	Transgender Other
Current Sex: Male	Female	Transgender Other
Marital Status: (Circle One) Married	Single	Divorced Widowed
Employment: (Circle One) Employed	Retired	Disabled F/T Student
Employer:		Referring Physician:
How did you hear about us?		
EMERGENCY CONTACT INFORMATION		
First Name:	Middle:	Last:
Relationship:		
Home Phone ( )	Work Phone: ( )	Cell: ( )
PRIMARY INSURANCE INFORMATION		
PLEASE PROVIDE INSURANCE CARD TO FRONT DESK		
Insurance:	ID#:	Group#:
Name of Insured:	DOB:	SS#
SECONDARY INSURANCE INFORMATION		
Insurance:	ID#:	Group#:
Name of Insured:	DOB:	SS#
SPOUSE/GUARANTOR / RESPONSIBLE PARTY		
Social Security #:	Sex:	Date Of Birth:
Relationship:		Daytime Phone ( )
First Name:	Middle:	Last:
Address:	City:	State: Zip:
Employer:	Address	
City: State:	Zip:	

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired throughout my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible for payment of non-covered services.

Signature (Patient or Parent if Minor) Date

Patient Health History

Today's date: _____

Patient name: _____ **Date of birth:** _____

Chief complaint/ Reason for visit _____

_____

Local Pharmacy Name and Number (No mail order)

_____

Referring physician: _____

Please list your current providers:

Primary care: _____

Cardiology: _____

Nephrology: _____

Gastroenterology: _____

Pulmonary: _____

Chronic pain management: _____

Other: _____

Social history

Do you currently smoke? ____ How much/ day? _____ Former smoker? _____

E-cigarettes/ vape? _____ Alcohol use? _____ If yes, how much? _____

Recreational substance use? _____

Medication allergies with reaction _____

_____

No known Medication allergies _____

Are you allergic to: Latex Adhesives Iodine CT contrast dye Shellfish

Do you have any of the following:

Implanted port/ implanted devices_____ Metal in your body_____

Today's date: _____

Patient name: _____ Date of birth: _____

Current Medications, including over the counter and supplements.

List Attached _____ Not taking any medications _____

If list attached, do not write below.

Name of medication	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any aspirin or blood thinners?

Aspirin / dose _____ Eliquis (apixiban) / dose ____ Plavix (clopidegrel)

Xalrelto / dose _____ Coumadin (Warfarin / dose _____

Brilinta (tigagrelor)_____ Effient (prasugrel)_____ Other _____

Today's date: _____

Patient name: _____ Date of birth: _____

Past Medical History:

Endocrine

Diabetes _____ Last Hgb A1c _____

Thyroid disease _____

Musculoskeletal

Arthritis _____

Lupus _____

Cardiovascular

High blood pressure _____

Congestive heart failure ____

Coronary artery disease ____

Pacemaker/ Defibrillator ____

Heart attack _____ (year) _____

Cardiac stents _____

Gastrointestinal

Diverticulitis _____

GERD (Heartburn) _____

Colon cancer _____

Gallstones _____

Irritable bowel _____

Cirrhosis_____

Hepatitis _____

Respiratory

Asthma _____

COPD/ emphysema _____

Oxygen use _____

Sleep apnea ____

Renal

Kidney stones _____

Dialysis _____

Hematologic

Bleeding/ clotting disorder _____

History of blood clot _____

Neurologic

Stroke/ TIA _____

Seizure disorder _____

Cancer History _____

Today's date: _____

Patient name: _____ Date of birth:_____

Previous Surgical History:

Abdominal Surgeries - Please list year

Appendectomy ___

Gallbladder ____

Splenectomy ___

Hysterectomy _____

C section _____

Colon/ bowel surgery ____

Bariatric (weight loss) ____

Other _____

Hernia - Please list year

Inguinal (groin) R/ L _____

Incisional ____

Umbilical _____

Abdominal wall _____

Hiatal/ Diaphragm _____

Other _____

Cardiac/ vascular surgery - Please list year

Coronary bypass (CABG) _____

Aneurysm repair _____

Peripheral stent/ vascular bypass _____

Other surgeries - Please list year

_____

_____

Family history:

	Father	Mother	Brother	Sister
Diabetes				
Heart disease/ attack				
Stroke				
Bleeding problems				
Cancer (type)				
Reaction to anesthesia				
Sickle cell				
Other ( )				

Today's date: _____

Patient name: _____ Date of birth: _____

Review of Systems:

Have you had any of the following in the ***last 30 days:***

General/ constitutional

Recent weight gain or loss ____

Fever _____

Feeling fatigued ___

HEENT

Headaches ____

Hearing loss _____

Bleeding gums ____

Vision changes ____

Cardiovascular

Chest pain ____

Palpitations ____

Chest pain when climbing stairs ____

Respiratory

Cough ____

Wheezing ___

Shortness of breath with activity such as walking or climbing stairs ____

Gastrointestinal

Bloody or black tarry stool ___

Jaundice ___

Nausea ___

Vomiting _____

Heartburn ____

Constipation _____

Diarrhea ____

Genitourinary

Urinary frequency ____

Blood in urine ____

Psychiatric

Anxiety ___

Depression _____

Neurologic

Dizziness ___

Confusion ____

Skin

Rash ___

Change in skin lesion ____

New mass or lump _____

Hematologic/ lymph

Easy bleeding ____

Easy bruising _____

Swollen lymph nodes _____

UNIVERSITY MEDICAL GROUP

Patient Privacy Questionnaire and Notification

Patient Name:_____ Date of Birth:_____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at*: _____Home #_____

_____Cell #_____

_____Work #_____

_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).

_____May leave appointment reminders on my answering machine/voicemail.

_____May leave lab results on my answering machine/voicemail.

_____May leave general questions/information on my answering machine/voicemail.

_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:_____Relationship:_____Contact#:_____

Name:_____Relationship:_____Contact#:_____

_____May leave appointment reminders with the above listed person

_____May leave lab results with the above listed person

_____May leave general questions/information with the above listed person

_____May discuss billing information with the above listed person

_____I prefer that all healthcare messages be given to the above listed person

*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient_____ Date_____