THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

University Neurology Cole Neuroscience Center
2200 Sutherland Ave.
Knoxville, TN 37919
(865) 521-6174 or Fax (865) 546-4065

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ **Date of birth:** _____

SSN: _____ **Address:** _____

_____

I hereby authorize the release of medical records to University Neurology Cole Neuroscience Center

Records to be released from: _____

For the following purpose: Medical Treatment

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment,
Condition or dates of treatment: _____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

_____

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 and 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-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient **Date**

University Neurology Cole Neuroscience Center
2200 Sutherland Avenue
Cherokee Mills
Knoxville, TN 37919

From I-40 Going East

- **Take Exit 386B Alcoa HWY (HWY 129)**
- **Take the Kingston Pike Exit (Route 70)**
- **Turn right (West) on to Kingston Pike**
- **The next red light is the intersection of Kingston Pike, Concord Street and Neyland Drive, take a right on to Concord Street**
- **The Next red light is the intersection of Concord Street and Sutherland Ave**

Our building is on the left, you may enter the parking lot from Concord Street or Sutherland Avenue

From 275 South or I-40 Going West

- **Take Exit 386B Alcoa Highway (HWY 129)**
- **Take the Kingston Pike Exit (Route 70)**
- **Turn right (west) on to Kingston Pike**
- **The next red light is the intersection of Kingston Pike, Concord Street, and Neyland Drive, Take a right on to Concord Street.**
- **The Next red light is the intersection of Concord Street and Sutherland Ave**

Our building is on the left, you may enter the parking lot from Concord Street or Sutherland Avenue

From Maryville

- **Take Alcoa Highway (HWY 129) North**
- **Take the Kingston Pike Exit (Route 70)**
- **Turn Left (west) on to Kingston Pike**
- **The next red light is the intersection of Kingston Pike, Concord Street, and Neyland Drive, take a right on to Concord Street**
- **The Next red light is the intersection of Concord Street and Sutherland Ave**

Our building is on the left, you may enter the parking lot from Concord Street or Sutherland Avenue

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DUE TO POSSIBLE TRAIN DELAY NEAR OUR LOCATION, WE HAVE INCLUDED AN ALTERNATE ROUTE

From I-40 Going East

- **Take exit 386A**
- **Continue straight to Middlebrook Pike and Sutherland Ave Intersection**
- **Go Straight on to Sutherland Avenue 0.9 miles**

CHEROKEE MILLS/UNIVERSITY NEUROLOGY COLE NEUROSCIENCE CENTER WILL BE ON YOUR LEFT.

From 275 South or I-40 Going West

- **Use the right lane to take exit 386B for U.S. 129/Alcoa Hwy**
- **Keep right**
- **Turn left on to Sutherland Avenue**
- **At the intersection of Middlebrook Pike and Sutherland Avenue, continue straight 0.9 miles**

CHEROKEE MILLS/UNIVERSITY NEUROLOGY COLE NEUROSCIENCE CENTER WILL BE ON YOUR LEFT.

From Maryville

- **Take Alcoa Highway (HWY 129) North**
- **Continue straight passing the Kingston Pike exit**
- **Staying right go toward 40/275 East/North**
- **Than take the 17th Street Western Avenue Exit**
- **At the stop sign, turn left on to Twenty First Street**
- **Second red light, turn left on to Middlebrook Pike**
- **At the next light turn left on to Sutherland Avenue**
- **Continue straight 0.9 miles**

CHEROKEE MILLS/UNIVERSITY NEUROLOGY COLE NEUROSCIENCE CENTER WILL BE ON YOUR LEFT.

Phone (865)521-6174
Fax (865)546-4065

University Neurology Cole Neuroscience Center
2200 Sutherland Avenue
Cherokee Mills
Knoxville, TN 37919

Appointment Date: **Arrival Time:**

We have reserved this time for you. Please give us 24 hours' notice if you cannot keep this appointment.

You will find directions to our office on the back of this page.

Dear New Patient:

Welcome to University Neurology Cole Neuroscience Center. We would like to make your visit as pleasant and productive as possible and in order to do that we need your help with the following.

- **Please take a few minutes to fill out the enclosed four-page history and bring to your visit.**
- **Bring any and all medical records with you to your appointment. It is especially important that your neurologist have the results of any test that you have taken due to your current medical problem, such as MRI's, CAT Scans, EEG's, Bloodwork, etc.**
- **Bring your recent CAT scan and MRI films/CD with you to your visit. This will allow your neurologist to review the images personally. Most radiology departments are willing to provide patients with a CD that has the images loaded.**

Having the above completed before your visit will help ensure that your physician has all the information needed to help you with your problem.

We look forward to serving you.

Phone (865)521-6174
Fax (865)546-4065

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:_____

Name:_____Relationship:_____

_____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.

Signature of Patient_____ 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

Email Address Race _____ Ethnicity _____

Gender (Circle as many as are appropriate)

Birth Sex: Male Female Transgender Other

Current Sex: Male Female Transgender Other

Marital Status (Circle One) Married Single Divorced Widowed

Home Phone ( )

Cell Phone ( )

(Circle One) Employed Retired Disabled F/T Student Other

Work Phone ( )

Employer Referring Physician

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance ID # GR #

Name of Insured DOB SS#

SECONDARY INSURANCE INFORMATION

Insurance ID# GR #

Name of the Insured DOB SS#

EMERGENCY CONTACT

Relationship

First Name Middle Last

Home Phone ( ) Work Phone ( ) Cell ( )

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security # Sex Date Of Birth

Relationship Daytime Phone ( )

First Name Middle Last Name

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 in the course of 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 to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) DATE

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

Date: _____/_____/_____

University Neurology Cole Neuroscience Center Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	☐ M ☐ F	DOB _____/_____/_____ AGE

Please list your doctors (starting with the doctor who referred you here):

Doctor:	Specialty:
_____	_____
_____	_____
_____	_____

CHIEF COMPLAINT

What is the reason for your visit today? _____

_____

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Operation:	Age or Year:

Other Hospitalizations:

Year	Reason

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	How much? When?	Name the drug	How much? When?
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

More on next page.

Local Pharmacy Name:
Address:
Phone:

Mail Order Pharmacy:
Address:
Phone:

Allergies to Medications (please list medication and problem it caused):

No Allergies - Please Circle

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Widower

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?_____How many drinks per week? _____

Drugs:
Do you currently use recreational or street drugs (cocaine, methamphetamine, marijuana, etc)? ....☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? .....☐ Yes ☐ No

What types of jobs have you held? _____

_____

What is your job now? _____

Toxic exposures: please list any (lead, arsenic, solvents, mercury, etc) _____

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

REVIEW OF SYSTEMS:

GENERAL

Have you had recent fever? ..... ☐ Yes ☐ No
Have you had recent weight loss? ..... ☐ Yes ☐ No
Do you have frequent / severe night sweats? ..... ☐ Yes ☐ No

ENDOCRINE

Do you have thyroid problems or goiter?	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No

HEAD, EYES, EARS, NOSE, AND THROAT

Do you have vision (eyesight) problems?	☐ Yes	☐ No
Do you have dry eyes?	☐ Yes	☐ No
Do you have trouble hearing?	☐ Yes	☐ No
Do you have ringing in your ears?	☐ Yes	☐ No
Do you have nosebleeds?	☐ Yes	☐ No
Do you have hoarseness?	☐ Yes	☐ No
Do you have sinus problems?	☐ Yes	☐ No
Do you have dry mouth?	☐ Yes	☐ No

GASTROINTESTINAL

Do you have trouble swallowing?	☐ Yes	☐ No
Do you have indigestion or heartburn?	☐ Yes	☐ No
Have you had ulcers?	☐ Yes	☐ No
Do you have frequent constipation?	☐ Yes	☐ No
Do you have frequent diarrhea?	☐ Yes	☐ No
Have you had hepatitis or liver disease (yellow jaundice)?	☐ Yes	☐ No
Do you have gallbladder disease?	☐ Yes	☐ No
Are you on a special diet? _____	☐ Yes	☐ No

PULMONARY

Do you have shortness of breath?	☐ Yes	☐ No
Do you have wheezing, asthma, or emphysema?	☐ Yes	☐ No
Have you had tuberculosis or a positive TB test?	☐ Yes	☐ No

CARDIOVASCULAR

Do you have hypertension (high blood pressure)?	☐ Yes	☐ No
Do you have heart disease (heart attack, heart failure, valve problem)?	☐ Yes	☐ No
Do you have a heart murmur?	☐ Yes	☐ No
Does your heart beat fast or slow (palpitations)?	☐ Yes	☐ No
Do you have high cholesterol?	☐ Yes	☐ No

NEUROLOGIC

Do you have headaches?	☐ Yes	☐ No
Have you ever had a seizure or convulsion?	☐ Yes	☐ No
Do you have a loss of sensation (numbness) anywhere?	☐ Yes	☐ No
Do you have a loss of muscle power anywhere?	☐ Yes	☐ No
Do you have tremor (shaking)?	☐ Yes	☐ No
Have you had a concussion or whiplash injury?	☐ Yes	☐ No
Do you have trouble sleeping? If so, what trouble?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you fall asleep driving or similar activity?	☐ Yes	☐ No
Do you have trouble walking?	☐ Yes	☐ No
Do you have trouble with you speech?	☐ Yes	☐ No
Do you have frequent dizziness?	☐ Yes	☐ No
Do you have motion sickness?	☐ Yes	☐ No
Do you have double vision?	☐ Yes	☐ No
Have you ever had a stroke?	☐ Yes	☐ No

More on next page

HEMATOLOGIC

Do you bleed or bruise easily? ☐ Yes ☐ No
Do you have anemia (low blood count)? ☐ Yes ☐ No
Do you have a history of B12 deficiency or Iron deficiency? ☐ Yes ☐ No

RHEUMATOLOGIC

Do you have a history of any rheumatologic disease (Lupus, Sjogrens Syndrome, etc) ☐ Yes ☐ No
Do you have arthritis or joint pain/swelling? ☐ Yes ☐ No
Do you have back or neck pain? ☐ Yes ☐ No

DERMATOLOGIC

Do you have any skin problems (rashes, acne, moles, etc)? ☐ Yes ☐ No
Have you had malignant melanoma? ☐ Yes ☐ No
Have you had any other form of skin cancer? ☐ Yes ☐ No

PSYCHOLOGIC

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No
What degree of stress do you have:
At Home? _____
At Work? _____
Other? _____

WOMEN ONLY-GENITOURINARY

Number of pregnancies _____ Number of live births _____
Have you ever had a miscarriage (in which month did it happen)? ☐ Yes ☐ No
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
Have you had any bladder problems in the past year? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

MEN ONLY-GENITOURINARY

Do you usually get up to urinate during the night? ☐ Yes ☐ No..... If yes, # of times _____
Do you have any bladder problems? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Do you have any prostate problems? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

DOCTOR'S REVIEW

This form was reviewed with patient.

_____ _____/____/____
Physician Date