Vanderbilt Wellness PLLC

New Patient Packet

Patient Information

Full Legal Name: _____

Preferred Name: _____ DOB: _____

SSN: _____Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Occupation: _____ Marital Status: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

If patient is a minor under the age of 18
Parent / Legal Guardian: _____

Parent/ Legal Guardian Contact Phone: _____

Primary Care Physician: _____

Location: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

_____

I, _____, have provided this information to the best of my knowledge.

Signature: _____ Date: _____

Vanderbilt Wellness PLLC

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Medical History

Current Medications (Including vitamins and supplements):
Example: Lisinopril 10 mg, Ibuprofen as needed, Fish Oil, Vitamin D, Multivitamin

_____

_____

_____

_____

_____

Current Medical Conditions
Examples: High Blood Pressure, Low Back Pain, Anxiety, Cancer

_____

_____

_____

_____

_____

Have you ever had any surgeries? *(Circle one)* Yes No

Allergies: _____

_____

_____

Tobacco use (*Circle one)*: Yes No Formerly

Alcohol Use (*Circle one)*: Never Rarely Frequently Daily

I, _____, have provided this information to the best of my knowledge.

Signature: _____ Date: _____

Notice of Privacy Practices

The Vanderbilt Wellness clinic is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information. We are legally bound by the terms of this notice currently in effect. ***Please let us know if you have any questions regarding this notice.***

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS. PLEASE REVIEW CAREFULLY

"Protected Health Information," or PHI, is information about you. This includes demographic information and any information that can identify you and/or relate to your past, present, or future physical and/or mental health conditions and related health services. Your PHI is used in this clinic solely for your care and treatment. It cannot be used for research or advertisement purposes without your explicit permission. PHI cannot be disclosed with any person, business, or entity that is not you, without your explicit permission. You can directly provide us who you would like to have access or they may provide a copy of a Healthcare Power of Attorney. You may access your PHI through the EMR portal or you may request a paper or disc copy from the clinic for a fee.

Your PHI may be used and disclosed by your provider, our office staff, and those involved with your care and treatment for the purpose of providing health care services to you or as required by law. *Examples are, and not limited to, if we were to refer you to a specialist or your PCP requested information about your care here*.

Is there anyone you would like to put on file to be able to access your PHI. This person will be able to call the clinic on your behalf to request refills, make payments, or request your PHI. If there is no one, please print "No one". This will be considered to be in effect until updated.

Name of authorized person(s), their relationship to you, and their phone number:

_____

_____

_____

I, _____, have read this notice and certify that I understand and agree to its contents.

Signature: _____ Date: _____

General Consent for Care and Treatment

TO THE PATIENT: You have the right to be informed about your condition and about the recommended medical treatments, surgical, and diagnostic procedures so that you may make a confident decision to decline or accept any suggested medical treatments, surgical, and diagnostic procedures after knowing the potential risks and hazards involved. As a new patient, there is no specific treatment plan recommended. This consent form is to provide The Vanderbilt Wellness Clinic permission to perform the evaluation necessary to begin your care here.

PERMISSIONS: By signing this consent form, The Vanderbilt Wellness Clinic and its staff are granted your permission to perform reasonable and necessary medical examinations, testing, and treatment. This consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and provided. This consent will remain fully effective until revoked in writing and you have the right to do so at any time.

You, the patient, have the right to discuss any and all recommended medical examinations, testing, and treatment proposed to you by The Vanderbilt Wellness Clinic and its staff for the condition you are seeking care for. Additional consent will need to be signed prior to any recommended invasive or interventional procedures.

I have read this consent form and certify that I fully understand, agree, and voluntarily consent to its content and statements.

_____

Patient's Full Legal Name (Printed)

_____ _____

Patient or Legal Representative's Signature **Date**

_____ _____

Legal Representative's Name if Applicable (Printed) **Relationship to Patient**

_____ _____

Witness' Name (Printed) **Witness' Role**

_____ _____

Witness Signature **Date**