PATIENT INFORMATION – ESTABLISHED PATIENTS (Please fill out completely)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: (___)_____ Cell: (___)_____ Work: (___)_____

Email: _____ Where would you prefer to receive calls: Home / Work / Cell

Marital Status: Married / Single / Widowed / Divorced / Other: _____

Race: Caucasian / African-American / Asian / Hispanic / Other: _____

Ethnicity: American / African-American / Spanish / Asian / Other: _____

Preferred Language: English / Spanish / Other: _____

Employment: Employed / Unemployed / Retired / Disabled / Student / Other: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone Number: (___)_____

Emergency Contact Relationship: (Please Circle One) Spouse / Parent / Friend / Other: _____

Primary Care Physician: _____ Phone Number: (___)_____

Pharmacy: _____ Location: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy Number: _____

Name of Policy Holder: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

Phone Number: _____ Home / Cell / Work / Other: _____

Secondary Insurance Carrier: _____ Policy Number: _____

Name of Policy Holder: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

HIPAA RELEASE

Notice of Privacy Practices Acknowledgment

I understand under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge I have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand this practice has the right to change its Notice of Privacy Practices and I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. If you would like a copy of the HIPAA Notice of Privacy Practice please let us know by checking one of the boxes below. Please be advised you may ask for a copy at any time. There is a copy of the HIPAA Privacy Practice posted in the lobby and on our website, www.murfreesborodiabetes.com.

☐ Yes, I would like a copy of the HIPPA Privacy Practice for my records

☐ No, I would not like a copy, but understand I can request a copy at any time.

DISCLOSURE

B. Paul Turpin, MD, PLLC is here to help you in managing your illness and to help you receive the best medical care. However, we are unable to provide the best medical care if you are unwilling to come for your follow up appointments and/or get the proper testing completed. B. Paul Turpin, MD understands there may be a concern about missing work. The office is open at 6:30 am and closes at 4:30 pm to assist in helping with appointments to be completed before or after work hours.

B. Paul Turpin, MD, PLLC will not approve medication requests if you have not been in the office during your scheduled appointment times, nor had the proper testing completed. B. Paul Turpin, MD will not call in prescriptions. If you need a refill on a prescription, please contact your pharmacy. All mail order prescriptions are the patient's responsibility to mail.

PATIENT RELEASE

I _____ understand B. Paul Turpin, MD, PLLC will not release any of my medical information to anyone other than the names I have listed below. I understand I may remove names listed below at anytime. I understand B. Paul Turpin, MD, PLLC may release my information to another doctor, who has referred me to Dr. Turpin or a doctor who Dr. Turpin has referred me to. I understand B. Paul Turpin, MD, PLLC can download all of my medication history. Please list names of anyone we may speak to regarding your appointments or medical conditions.

Names and Relationship:_____

X_____

Signature Date

PATIENT QUESTIONAIRE

(please fill out completely)

Patient Name: _____ DOB: _____

Why are you here today? (please circle all which apply)
Diabetes / Thyroid / Hormones / Parathyroid / Calcium / Pituitary Gland / Other: _____

How long have you had this problem? _____

Please list any surgeries have you had and the year? _____

_____

Please list all the medications, milligrams, and frequency of all medications you are currently taking:

_____

_____

_____

Please list all medical issues/diseases you may have: _____

_____

Please list all medication allergies and reaction you have: _____

_____

Please list all food allergies and reaction you have: _____

What environmental allergies do you have? (please circle all which apply)
Grass / Dust / Pollen / Animal Dander / Mites / Other: _____

Family Medical History

	Diseases	If deceased, cause of death
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____
	_____	_____

Children: ______________________________ ____________

______________________________ ____________