Total Health Care Associates, PLLC
105 Ledford Mill Rd, Suite B
Tullahoma, TN 37388

PATIENT INFORMATION

Patient Name

_____

Last First Middle

Mailing Address

_____

Street City State Zip Code

Home/Cell Phone #	Business Phone #
Social Security #	Birth Date
Marital Status: S M W D Separated	Driver's License #

Employer or School

Address

_____

Street City State Zip Code

Whom May We Contact in an Emergency? Name: _____ Last First MI	Telephone # _____ Cell Phone # _____ Relationship to patient_____ _____

Primary Insurance Policy	Secondary Insurance Policy
Insurance Co. Name_____	Insurance Co. Name_____
Policy holder's name_____	Policy holder's name_____
Policy #_____	Policy #_____
Group # _____	Group # _____

Insured's Name

_____

Last First Middle

Address

_____

Street City State Zip Code

Home/Cell Phone #	Business Phone #
Social Security #	Birth Date

Responsible Party for Account

_____

Last First Middle

Individuals Authorized to Receive Information about YOUR ACCOUNT:

1. Name:_____ Phone #_____
   Relationship to patient: _____

2. Name:_____ Phone #_____
   Relationship to patient: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to Total Health Care Associates, PLLC.

Signed _____ Date _____

I hereby authorize Total Health Care Associates, PLLC, to furnish any information required to process my insurance claims.

Signed _____ Date _____

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Patient History Form

Name _____ DOB _____ Date _____/_____/_____

Address _____

Phone: Home _____ Work _____ Cell _____

Chief Complaint _____

Height _____ Weight _____ Pharmacy _____

Allergies

List drug, food and environmental allergies	Reaction

Current Medications

Drug Name	Dose	Drug Name	Dose

Surgical History

Surgery	Date	Surgery	Date

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Habits

□ **Smoke** _____packs daily
How long? _____
When stopped? _____
□ **Exercise Routine** _____
_____

□ **Coffee** _____ cups daily
□ **Other Caffeine** _____
□ **Alcohol:** Type/Amount _____
□ **Diet:** Salt Intake _____
Fat Intake _____

□ **Sleep**
□ Difficulty falling asleep
□ Continuity disturbance
□ Snoring
□ Early morning awakening

□ **Do you have a living will?** □ **Yes** □ **No**

Personal Medical History

Yes	Condition	Yes	Condition	Yes	Condition
	Diabetes		Fractures		PCOS
	High Blood Pressure		High Cholesterol		Seizures
	GI Reflux		Hepatitis		Migraines
	Other GI Disease		Liver problems		Anxiety/ Depression
	Cancer (type)_____		Kidney Infections/stones		Anemia/Blood Transfusion
	Heart Disease		Arthritis		Asthma
	Fibroids		Joint pain		Lung Disease
	Endometriosis		Ovarian Cyst		Tuberculosis
	Osteoporosis		Clotting Disorder		STDs
	Osteopenia		Thyroid Disease		Stroke

Family History

Family Member	Alive	Deceased	Age	Medical Problem or Cause of Death
Father				
Mother				
Spouse				
Siblings **Brothers _____** **Sisters _____**				
Children **Boys____** **Girls____**				

Personal Safety

Has anyone close to you ever threatened to hurt you?	□ YES □ NO
Has anyone ever hit, kicked, choked or hurt you physically?	□ YES □ NO
Has anyone, including your partner, ever forced you to have sex?	□ YES □ NO
Are you ever afraid of your partner?	□ YES □ NO