Family Medicine West of Wartburg

Patient Registration

→ **Name:** _____
Last *First* *Middle* *Maiden Name*

→ **Do you prefer to go by another name? If so, list it here:**_____

→ **Mailing Address:** _____

_____
City State Zip Code

→ **Phone:** _____**Cell Phone:** _____**Work:** _____

→ **Date of Birth:** _____ **Social Security #**_____

→ **Sex *(Circle your choice)*:** Male Female **Marital Status *(Circle your choice)*:** Single Married Divorced Widowed

→ **Ethnic Group *(Circle your choice)*:** American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Islander White Other ***(Please Specify)***: _____

→ *Do you have an Advance Directive (e.g., a living will or advance care plan)? (Circle)* ***Y N***

→ *Do you have a Power of Attorney? (Circle)* ***Y N***

********If YES to any of the above, please make sure we have a copy for your medical record********

INSURANCE INFORMATION

→ ***Primary Insurance***_____ ***Secondary Insurance***_____

→ **ID#**_____ **ID#**_____

→ **Group #**_____ **Group #**_____

→ **Insured**_____ **Insured**_____

→ **Insured's SSN**_____ **Insured's SSN**_____

→ **Insured's Date of Birth**_____ **Insured's Date of Birth**_____

→ **Pt's Relationship to Insured**_____ **Pt's Relationship to Insured**_____

→ ***Employer of Primary Insured***_____ ***Employer #***_____

**********IF THE PATIENT IS A MINOR: **********

→ **Who does the patient live with?** _____

→ **Relationship**_____**D.O.B**_____

→ **Address**_____

→ **City**_____**State**_____**Zip**_____

→ **Custody Issues (Circle Choice)? Y N**

********If answered YES to the previous question, please provide documentation of custody********

EMERGENCY CONTACT

→ **In Case of Emergency Please Contact**:_____

→ **Phone:** _____**Relationship:** _____

I hereby authorize Family Medicine West to furnish information to and obtain information from insurance carriers, healthcare providers and/or facilities concerning my illness and treatment. I hereby assign to FMW all payments for medical services provided to my dependents or me. I understand that I am responsible for any charges not covered by insurance, managed care, government or other provider. If my insurance refuses payment, I understand that I am responsible for all charges. I understand that further non-emergent care may be denied if my account is not paid.

→ _____ _____
Patient/ Guardian Signature Date

FAMILY MEDICINE WEST OF WARTBURG

CONTACTING YOU

Patient's Name _____ DOB_____

Date: _____

Contact Number:

Home: _____ Work: _____

Mobile: _____

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, billing problems or any other situations relating to your visit at our office. Please read and answer the following questions.

I give permission to this office to call the ***home number*** I've listed above and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

I give permission to this office to call the ***mobile number*** I've listed above and leave test results, appointments and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

I give permission to this office to call the ***work number*** I've listed above and leave test results, appointments and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

If you believe someone other than yourself may be calling the facility regarding your care, we ask that you list both the name and the relationship of the caller so that we have written permission to speak with them on your behalf.

☐ **I do not want information released to anyone other than myself, including my spouse.**

1._____ 2._____

3. _____ 4. _____

Check the information we may release to this person(s):

☐ **Appointment Info**
☐ **Account Information**
☐ **Medical Records**

Family Medicine West of Wartburg-Initial Visit

Sanjay Thakur M.D. **Mary Ann Hammonds ANP.** **Patient: _____**
Angela Brown F.N.P. **Katie Gresham F.N.P** **Date of Birth: _____**
Date: _____

Please help us update your medical records at our new Family Medicine West Office, by answering these few questions. We hope this will help enhance and expedite your care. We thank you for your confidence in FMW.

Assigned Sex at Birth: Male Female

What gender do you identify with currently? Male Female

Do you have any DRUG ALLERGIES?

_____

What medications do you take (name and dosage)?

_____

_____

_____

_____

What are your past medical problems (ie: High Blood Pressure, High Cholesterol, etc.)?

_____

_____

_____

What are all of your previous surgeries?

_____

_____

_____

Family History: Heart Attack Yes or No Blood Pressure Yes or No Cancer Yes or No
Diabetes Yes or No

Tobacco Use: Yes or No **Alcohol Use:** Yes or No **Caffeine Use:** Yes or No

Mental Health History: Yes or No **Communicable Diseases (ie: STD):** Yes or No

Do you see any other Healthcare Providers (ie: Cardiologist, Orthopedist, etc. if so who?

_____

_____

_____

Reason for TODAY'S visit?

_____

_____

_____

FAMILY MEDICINE WEST OF WARTBURG

1236 Knoxville Hwy. Suite 500
PO Box 308
Wartburg, TN 37887
(phone) 423-346-5566 (fax) 423-346-4629

Please fill out each section in its entirety. If you **do not** have the **full address** or **phone number and fax number**, please call back with the information.

Patients Name: _____

SSN: _____-_____-_____ **DOB:**_____

Purpose of Request:
☐ At the request of the individual for primary care facility
☐ Other (Please list)_____

Physician to **Provide** Records:

Doctor's Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

Person/Facility to **Receive** Records:

Address: **Family Medicine West of Wartburg**
1236 Knoxville Hwy. Suite 500
PO Box 308
Wartburg, TN 37887
Ph: 423-346-5566 Fax: 423-346-4629

If the person or entity receiving this information is not a healthcare provider or health plan covered by Federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. Patient may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the trial is completed. Finally, you may revoke this authorization at any time. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive you request to revoke authorization. This release expires in 30 days.

_____ _____
Patient Name (print) Person Authorized to sign

_____ _____
Patients Signature Authorized Signature

Date: _____ Relationship: _____

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1236 Knoxville Hwy. Suite 500
PO Box 308
Wartburg, TN 37887
Phone: 423-346-5566 Fax: 423-346-4629

Please fill out the Name, Date of Birth, and the Date.
If you would like to opt-in to our Patient Portal System, Check Yes or No below.
If you check **Yes**, please (clearly) write your e-mail address below.

Name (Print Please):_____

Date of Birth:_____

Date:_____

☐ **Yes** ☐ **No**

Email: _____

Questions?

What Is a Patient Portal?

A patient portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—called an Electronic Health Record or EHR—from anywhere with an Internet connection.

Why Is a Patient Portal Important?

Accessing your personal medical records through a patient portal can help you be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily. Also, patient portals offer self-service options that can eliminate phone tag with your doctor and sometimes even save a trip to the doctor's office.

Can my family access my Portal?

You may choose to give family members, such as parents or healthcare proxies, access to your Portal.

Is my information safe?

Yes. Patient portals have privacy and security safeguards in place to protect your health information.

Always remember to protect your user name and password from others and make sure to only log on to the patient portal from a personal or secure computer.

Family Medicine West

https://www.FamilyMedicineWest.mymedaccess.com

Phone: 865-288-4232
Fax: 865-288-4231

220 Fort Sanders West Blvd.
Building 2 Suite 200
Knoxville, TN 37922

Family Medicine West
Invites you to join our
Patient Portal

Access to YOUR health information…
Anytime
Anywhere

e-MDs

Registration is Easy!

Provide us with your preferred e-mail address so we can give you access to the Patient Portal

↓

A Portal Registration e-mail is automatically sent to you containing a registration link

↓

Click on the registration link

↓

Enter the requested personal information to verify your identity

↓

Follow the instructions for creating a user name and password

↓

Confirm your personal and insurance information on the next screen

↓

EXPLORE!

Patient Portal Website:

https://www.FamilyMedicineWest.mymedaccess.com

Online Help!

There is an online help system that will explain how to use each feature in the Patient Portal.
Look for the question mark button in the upper right hand of the Patient Portal.

See all of your health information in one place!

Lab Results
Radiology Reports
Allergies & Medications
Vital Signs
Past Medical History

Upcoming & Past Appointments

What Do I Do If…

…I don't receive a registration email?

Be patient. The e-mails may take a few minutes to deliver. You may also check your junk mail or spam folders to see if the email was routed there by mistake. If necessary, you can call the office to re-send the registration e-mail.
Also, failure to register your portal account within thirty days will inactivate your registration. If this happens, please contact the office to send you a new registration.

…I forget my password?

After you attempt to login with a username and password, click on the link that says, "Forgot Password," and follow the additional instructions. If you still need help, contact the office to reset your account.

…I have an urgent issue or an emergency?

Do NOT use the Patient Portal. Call the office if you need to speak with a staff member immediately. If you are experiencing an emergency, call 911 or go to the nearest emergency room.