McMillion Medical Group

400 Whitesport Drive, Suite 201, Huntsville, AL 35801 Phone (256) 489-3836 Fax (256) 489-3940
David McMillion, MD Christina Cantey, CRNP Jessica Walters, CRNP Tiaya Lang, CRNP

Patient Registration

Name: _____ **Referred Here By:** _____

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

Home Phone: _____**Cell:**_____ **Gender:** _____ **DOB:** _____

Email: _____

Preferred Language: _____ **Race:** _____ **Circle one: Hispanic or Non-Hispanic**

Age: _____ **SSN:** _____ **Drivers Lic. #:**_____ **Marital Status:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Employer Address: _____ **Date of Employment:** _____

Spouses Name: _____ **Spouses Employer**_____

Spouses Occupation: _____ **Spouses Work Phone:** _____

Emergency Contact: _____**Relation:**_____ **Phone:** _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Group#_____ **Contract#:**_____ **Co-pay**_____

Name of Insured: _____ **Relation to Patient:** _____

Sex: _____ **DOB:** _____ **SSN:** _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Group#_____ **Contract#:**_____ **Co-pay**_____

Name of Insured: _____ **Relation to Patient:** _____

Sex: _____ **DOB:** _____ **SSN:** _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize McMillion Medical Group to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to the party who accepts assignment. I certify that the information I have reported with regard to the patient's insurance coverage is correct.
I hereby acknowledge that I accept legal responsibility for all changes in connection with medical care provided by McMillion Medical Group to myself, my minor child or as guardian of the above patient. I understand that my insurance company may not reimburse all of my charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State / Federal law. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency.

Signed_____ Date: _____

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Patient Health History Ages 15 and Over

Name:_____ **Date of Birth:**_____ **Age:**____ **Today's Date:**_____

Last Doctor:_____ **Reason For Leaving:**_____

Other Doctors (Specialists):_____

Current Symptoms:_____

_____

Drug or Food Allergies (What happens to you?):_____

_____

Past Medical History (Check or Write In)

- ☐ Allergies (Seasonal)
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Breast Lump
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ GERD (Reflux)
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Liver Disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psychiatric Disease
- ☐ Poor Circulation
- ☐ Seizure Disorder
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Venereal Disease (STD)
- ☐ Other
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Surgeries

Surgery	Date / Location	Surgeon

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Patient Health History Ages 15 and Over (Continued)

Name:_____ **Today's Date:**_____

Medications

Preferred Pharmacy:

Local:_____

Mail Order:_____

Medication: *(Lisinopril)*	**Strength:** (10 mg)	**Instructions:** (One pill by mouth once per day)	**30/90 Days?**

201.8
Mc
Family Medicine

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Patient Health History Ages 15 and Over (Continued)

Name:_____ Today's Date:_____

Family History

In each box please write age of disease onset	Addiction	Anxiety	Arthritis	Bleeding Disorder	Cancer (Type)	Colitis	Dementia	Diabetes	Eye Disease	Heart Attack	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Lung Disease	Migraines	Osteoporosis	Psychiatric Disease	Stroke	Thyroid Disease	Other
Mother																						
Father																						
Sister																						
Brother																						
Grandmother																						
Grandfather																						

OB /GYN

Age of first menstrual period _____
Last menstrual period _____
How long do your periods last? _____
How heavy are they? _____
Any pain with your periods? _____
Associated with PMS or PMDD? _____
Are your periods regular? _____
Age of menopause _____
Any bleeding since menopause? _____
Number of pregnancies _____
Number of births <36 weeks _____
Number of births >36 weeks _____
Number of miscarriages _____
Number of living children _____
Your age when first child was born _____
Has your mom or dad had a hip fracture? _____
Do you have a BRCA mutation? _____
Have you ever had a breast biopsy? _____
If so how many? _____
If so how many were abnormal? _____

Personal History

Marital Status_____
Education_____
Occupation_____
Alcohol? ____Amount and type_____
Do you smoke? _____
How many packs a day? _____
Did you ever smoke? _____
When did you quit? _____
When did you start? _____
Do you use drugs? _____
Have you ever used drugs? _____
What kind? _____
Are you sexually active?_____
With men, women or both_____
Do you exercise? _____
What kind of exercise and how often?_____
_____
_____
_____
How much caffeine per day? _____
_____
Toxic exposure?_____
Hobbies_____
_____
_____

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Patient Health History Ages 15 and Over (Continued)

Name:_____ Today's Date:_____

Symptoms (in the last 6 months)

General

- Fever ☐
- Chills ☐
- Fatigue ☐
- Weight loss ☐
- Skin changes ☐

EENT

- Hearing changes ☐
- Vision changes ☐
- Double vision ☐
- Ringing in ears ☐
- Dizziness ☐
- Eye pain ☐
- Ear pain ☐
- Nose bleeds ☐
- Hoarseness ☐

Cardiovascular

- Chest pain ☐
- Chest tightness ☐
- Irregular beat ☐
- Rapid heartbeat ☐
- Ankle swelling ☐
- Varicose veins ☐
- Exercise intolerance ☐

Pulmonary

- Persistent cough ☐
- Wheeze ☐
- Blood in sputum ☐
- Short of breath ☐
- Painful breathing ☐
- TB exposure ☐

Gastrointestinal

- Poor appetite ☐
- Swallowing problems ☐
- Heartburn ☐
- Vomiting ☐
- Constipation ☐
- Diarrhea ☐
- Gas ☐
- Bloating ☐
- Excessive thirst ☐
- Hemorrhoids ☐
- Nausea ☐
- Stomach pain ☐
- Blood in stools ☐
- Blood in vomit ☐
- Change in stools ☐
- Tarry stools ☐

Musculoskeletal

- Joint pain ☐
- Joint swelling ☐
- Joint stiffness ☐
- Joint deformity ☐
- Muscle pain ☐
- Weakness ☐
- Muscle cramps ☐

Neurological

- Weakness on one side ☐
- Headache ☐
- Fainting ☐
- Seizures ☐
- Loss of balance ☐
- Tremor ☐

Genitourinary

- Painful urination ☐
- Blood in urine ☐
- Can't hold urine ☐
- Can't urinate ☐
- Weak stream ☐
- Going too often ☐
- Increased night time urination ☐
- Discharge: Penile / Vaginal ☐

Psychiatric

- Change in mood ☐
- Loss of pleasure ☐
- Can't sleep ☐
- Too much energy ☐

Health Maintenance/ Immunizations

	When?	Result
Aneurysm Screen:	_____	_____
Last Blood Work:	_____	_____
Last Stress Test:	_____	_____
Last Colonoscopy:	_____	_____
Last DEXA Scan:	_____	_____
Last Eye Exam:	_____	_____
HIV Screen:	_____	_____
Last Mammogram:	_____	_____
Last Pap Smear:	_____	_____

Last Flu Vaccine	_____
Last Pneumonia Vaccine	_____
Last Tetanus Vaccine	_____
Last Chicken Pox Vaccine	_____
Last HPV (Gardasil) Vac.	_____
Last Shingles Vaccine	_____

Reviewed By:_____ Date:_____

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Receipt of Privacy Practices
Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____, was provided a copy of McMillion Medical Group's Privacy Practices Notification. McMillion Medical Group may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize McMillion Medical Group to use or disclose my PHI in conjunction with McMillion Medical Group's treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature of Patient / Guardian **Date**

Further I hereby authorize and give my consent to McMillion Medical Group to leave messages on my answering machine / voicemail for the following (check all that apply):

Appointment Reminders	_____	**Prescription Refills**	_____
Medical Information	_____	**Test Results**	_____
Insurance / Payment Issues	_____	**Mail**	_____

I further authorize and give consent to McMillion Medical Group to communicate any of my PHI to the following person / persons:

Name	Relationship	Phone Number

_____ _____
Signature of Patient / Guardian **Date**

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Authorization for Release / Request of Protected Health Information

Patient's Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Email: _____

SSN#:_____ **Patient's Phone #:**_____

Date of Request: _____ **Date Information Needed:** _____

☐ I Authorize David A. McMillion,MD To RELEASE information to:	OR	☐ I Authorize David A. McMillion,MD To RECEIVE information from:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, ZIP		_____ City, State, ZIP
_____ Phone and Fax #		_____ Phone and Fax #

Reason for this request:

☐ Healthcare ☐ Insurance ☐ Personal ☐ Other

Type of Records Requested:

☐ Consult ☐ Lab Results ☐ Imaging Results
☐ Discharge Summary ☐ Office Notes ☐ Other
☐ History and Physical ☐ Operative Report

☐ Medical Records Related to a Specific Illness or Injury and Date_____

☐ All Medical Records

- I understand that my right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for requested records.

_____ Signature of Patient or Guardian

_____ Date