Chet Gentry, MD ~ Matthew King, MD
Katie Wayne, FNP ~ Sandy Thompson, FNP
3300 Williams Enterprise Drive, Suite 1, Cookeville, TN 38506
Office: (931) 528-9222 ~ Fax: (931) 854-0907

We are happy to welcome you as a new patient to our practice!

As a member of our practice, you and your family will be cared for by a team of dedicated healthcare professionals. Our goal is to help you be as healthy and fit as possible: mentally, physically, and spiritually. We will teach you how to manage your own health as cost effectively as possible while we develop a medical care plan tailored to your needs. We will assist you in making sure that your medical needs are addressed wherever you are: Home, ER, Hospital, Home Health, Nursing Home, or Hospice. We strive to manage your care no matter where you go in the health system.

Office Hours

Monday – Friday 8:00 AM – 5:00 PM. The schedule of individual providers varies.

Same Day Appointments/Work-Ins (for existing patients)

Though you may choose a preferred provider in our practice, there may be times when you will need to be seen by one of the other members of our team. All appointments are to be scheduled in advance to properly accommodate each patient's needs. However, we understand that health concerns may arise suddenly. Same day appointments or work-ins will be scheduled with an available qualified provider upon approval. Each physician assistant and nurse provider in our practice consults with Dr. Gentry when the need arises.

Nurse Calls

If you have a question about your care, feel free to call and leave a message for one of the nurses. Someone will return your call within 48 hours during the business week. You may also be able to contact the provider team through the patient portal. Please do not leave a message if the issue is urgent or life-threatening.

Medication Refills

Unless you have an appointment scheduled to discuss refills, please call the office for prescription refills at least 72 hours prior to your medication running out. In some instances, you will be required to first make an appointment with a provider.

Lab Studies

All lab studies must be ordered by one of our healthcare providers. If you are concerned that you have a condition that requires a lab study (strep test, urinary screening, etc.), you must first make an appointment with the provider.

Same Day Cancellations/No shows

We are committed to providing all of our patients with exceptional care. When a patient does not show up or cancels without giving adequate notice, they prevent another patient from being seen. Please call our office by 3:00 PM on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call us by 3:00 PM on Friday. A patient is considered a no show if they do not come in or if they arrive more than **20 minutes** past their appointment time. **Patients will be billed a $25 same-day cancellation/no-show fee, which is not billable to insurance.** Patients who arrive late will be seen only at the discretion of the provider. In the case of heavy snow/storms, the fee is waived. Excessive **(3 or more)** no-shows may result in patient discharge from the practice.

Feedback

Please let us know how we are doing by emailing us at info@innovativefamilycare.com or by speaking to a member of our team. We are constantly striving to improve!

Innovative Family Care, PLLC

Chet Gentry, MD ~ Matthew King, MD

Katie Wayne, FNP ~ William Wilson, FNP ~ Sandy Thompson, FNP

Patient Information:

Name: _____ DOB: ___/___/_____ Age: _____ Sex: □ Male □ Female

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

Marital Status: □ Single □ Married □ Divorced □ Widowed, Social Security #: _____ - _____ - _____

Contact Information:

Cell Phone: (____) _____

Home Phone: (____)_____

Preferred contact number? □ Cell □ Home

Permission to leave voicemail/send message?

□ Yes □ No

□ Yes □ No

Employer: _____ Employer Phone (____)_____

Optional:Race (Check one)

____ American Indian/Alaskan Native
____ Asian
____ Black/African American
____ Native Hawaiian or other Pacific Islander
____ White

Optional: Ethnicity (Check one)

____ Of Hispanic Descent
____ Not of Hispanic Descent

E-mail: _____

Would you like Portal Access? □ Yes □ No

Preferred Pharmacy_____

Pharmacy Location_____

Emergency contact: Name _____ Relation_____ Phone (____)_____

Responsible Party or Bill to Information: □ Check if the same as above

Relationship: _____

Name: _____ DOB: ___/___/_____ Age: _____ Sex: □ Male □ Female

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

Social Security Number: _____ - _____ - _____

□ **I have given <u>all of my</u> INSURANCE CARDS to the front desk for copying, including Medicare if applicable.***

***Please Note: You are required to present your insurance cards at EVERY visit.

Authorizations

- I understand that I am financially responsible for services rendered by the healthcare provider(s) and his/her staff regardless of insurance, including reasonable attorney's fees and costs of collection, in the event of default. I authorize my insurance company to pay benefits directly to Innovative Family Care PLLC.
- I understand that any patient under the age of 18 must be accompanied by an adult and, if not the parent(s), provide written authorization to make decisions on his/her behalf.
- I understand all the above and hereby state that the information is correct to the best of my knowledge.
- I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Innovative Family Care, PLLC.
- These authorizations apply to all occasions until revoked. I give my consent for disclosure of my protected health information for purposes of treatment, prescription history consent, payment, daily operations, and other disclosures as specifically listed on the Notice of Privacy Practices given to me by Innovative Family Care, PLLC.

Signature of Patient or Authorized Party: _____ Date: _____

Relationship to the patient: _____

INS INFO Reviewed/ Adj Practice Ptnr By _____ Date _____ PT DATA Reviewed/ Adj Practice Ptnr By _____ Date _____

Innovative Family Care, PLLC

3300 Williams Enterprise Drive, Suite 1
Cookeville, TN 38506
Office: 931-528-9222 ~ Fax: 931-854-0907

Record Release Authorizations

Patient Name: _____ DOB: ___/___/_____

HIPAA (Health Insurance Portability and Accountability Act of 1996) protects your rights to privacy. We cannot provide any information to family (including spouse, siblings) and/or friends about you or your health status UNLESS you give us written permission. We can only provide information to those people listed on this form. Examples of HIPAA protected information include appointment dates and times, test results, x-rays, prescriptions, surgeries, office notes, etc.

You have the right to revise &/or revoke this form at any time by personally completing an updated form.
This information will be scanned into our computer system by our medical records department for reference in the future.

Who we may release your medical information to:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Patient or Authorized Signature*: _____ Date:_____

*If not the patient, please provide printed name _____

* Relationship to patient _____

Innovative Family Care, PLLC

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Authorization for Disclosure of Health Information

The purpose of this form is to allow our office to communicate effectively with other providers involved in your care.

Patient Name: _____ DOB: ___/___/_____
Address: _____ City:_____ State: _____ Zip:_____
Cell Phone: (____)_____ Home Phone: (____)_____

~~~ FOR OFFICE USE ONLY~~~

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
   Name: _____
   Address: _____ City:_____ State: _____ Zip:_____
   Phone: (____)_____ Fax: (____)_____

3. The type and amount of information to be used or disclosed is as follows:
   ___ Complete Health Record
   ___ Physical exam
   ___ Immunization record
   ___ Lab/Imaging results
   ___ Consultation
   ___ Other (please specify):_____

4. Purpose of Disclosure: _____

5. I understand that if my records contain information relating to venereal diseases, hepatitis, HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

6. The information may be disclosed to the following organization:
   Innovative Family Care
   3300 Williams Enterprise Drive, Suite 1, Cookeville TN 38501
   Phone: 931-528-9222 Fax: 931-854-0907

7. I understand that I have the right to revoke this authorization at any time and, if I revoke this authorization, I must do so in writing by presenting my written revocation to the medical records department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

8. I understand that the HIPAA Privacy rule permits a provider to release information to my Health Insurance Carrier and to any other health provider for my treatment without my authorization. (45 CFR 164.506)

Patient or Authorized Signature*: _____ Date:_____

*If not the patient, Printed name _____& Relationship to patient _____

Patient Portal

Innovative Family Care allows you to access your health information electronically through secure email by use of our Patient Portal. Please complete the following if you wish to have access.

Patient Name: _____ DOB: ___/___/_____

Email address: _____

Create a username (All lower case letters, no spaces): _____

LOGGING ON TO THE PORTAL:

To access your information, go to our website: www.innovativefamilycare.com.

Select **PATIENT PORTAL** from the sidebar. Click on the link that will pop up. This will take you to the Login Screen. Enter the username you have created above.

Your initial password will be: **Password2#**
You will be asked to change the password when you enter for the first time. The password you create must be at least 8 characters and contain a capital letter, lowercase letter, a number and a symbol. No spaces are allowed.

If you need to reset your password, click the link that says, "If you are a patient and have lost your password". It will ask you for your username and will ask the question that you create below. The system will then email you another temporary password.

Password reset question (example: city of mother's birth): _____

Password reset answer: _____

You will be able to see your lab and x-ray results, visit summaries, and communicate with the providers. When you send messages, please allow 48 hours (2 business days) for a response. When your response arrives, you will be notified by email to check your messages in the portal. DO NOT use the Portal to communicate information of an urgent nature.

Insurance Information

(Please include a copy of your card, front and back)

Name of Primary
Insurance: _____

If this is a Medicare Advantage plan, check here ____

Policy #: _____

Group #: _____

Name of Insured: _____

DOB: _____
Employer: _____
Gender: □ male □ female
SS#: _____
Relation to Patient: _____

Name of Secondary Insurance: _____

If this is a Medicare Advantage plan, check here ____

Policy #: _____

Group #: _____

Name of Insured: _____

DOB: _____
Employer: _____
Gender: □ male □ female
SS#: _____
Relation to Patient: _____

Innovative Family Care

New Patient Health History

Name: _____

Date of Birth: _____ **Today's Date:**_____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Reason for visit?

_____

_____

Which Pharmacy do you use? _____ Location? _____

Home and Family

If female, number of children born Living: ____ Stillborn: ____ Miscarriages: ____

Who lives with you? _____

Job Status: ☐ Working Occupation: _____ Employer: _____
☐ Student ☐ Unemployed ☐ Retired ☐ Disabled From occupation: _____

If under age 18 or not adult status:

Mother's Name _____ Father's Name_____

Who is legal guardian?_____

Highest Education Level Completed: ☐ Grade school ☐ High school ☐ College ☐ Graduate degree

Special needs/services required:_____

Hobbies/Extracurricular activities: _____

Dwelling structure: ☐ House ☐ Apt /Condo ☐ Trailer ☐ Dorm ☐ Assisted Living – facility? _____

Spiritual

Faith/religion: _____ Congregation/place of attendance: _____

Lifestyle

Do you? If yes, how much? _____

Smoke tobacco: ☐ Yes _____ packs per day or ____ cigarettes/cigars per day
☐ Former ☐ Never

E-Cigs/Vape ☐ No ☐ Yes

Chew tobacco ☐ No ☐ Yes ___ tins/pouches per day

Drink caffeine ☐ No ☐ Yes ___ drinks per day

Drink alcohol ☐ No ☐ Yes ___ drinks per day

Use street drugs ☐ No ☐Yes Type? _____

Exercise: ☐ No ☐ Yes Type/Frequency?_____

Health History Name_____ Date of Birth_____

Who is/was your previous primary care physician? _____

What other specialists are you currently seeing or have seen recently? _____

Childhood Illnesses (Circle the diseases you had)

Chicken Pox
Chronic ear infections
Diphtheria
Measles
Meningitis
Mononucleosis
Mumps
Pertussis
Polio
Rheumatic Fever
Scarlet Fever
Strep Throat

Medical Problems (circle the problems you have; give any additional details below each section)

Endocrine/Metabolic: Diabetes, Polycystic Ovary Syndrome, Thyroid Problem, High Cholesterol, Osteoporosis, Low Testosterone, Menopause

Eyes, Ears, Nose, Throat: Cataracts, Glaucoma, Retinopathy, Hearing Loss, Tinnitus

Cardiovascular: Hypertension, Coronary Artery Disease, Heart Attack, Stents, Bypass Surgery, Congestive Heart Failure, Heart Murmur, Peripheral Vascular Disease (PVD), Cerebrovascular Disease, Stroke, TIAs, Carotid Artery Disease, DVT, Blood Clots to Lung or Leg, Venous Insufficiency

Respiratory: COPD of Emphysema, Asthma, Chronic Bronchitis, Sleep Apnea, Pulmonary Fibrosis, Pneumonia

Gastrointestinal: GERD, Peptic Ulcer Disease, Irritable Bowel Syndrome, Crone's Disease, Ulcerative Colitis, Constipation, Diarrhea, Hemorrhoids, Cirrhosis, Pancreatitis

Genitourinary: BPH, Incontinence, IC, Recurrent UTI, ED, Hernia

Obstetrical/GYN: Contraception, Problems in Pregnancy, Endometriosis, Dropped Bladder

Musculoskeletal: Osteoarthritis, Degenerative Joint Disease, Bulging Discs, Chronic Injuries, Plantar Fasciitis, Carpal Tunnel, Contractures, Scoliosis, Fracture

Renal: Chronic Kidney Disease, Kidney Stones

Neurologic: Seizures, Neuropathy, Deficits from CVA, Tremors, Parkinson's, Alzheimer's, Dementia, Restless Legs, Reflex Sympathetic Dystrophy, Multiple Sclerosis, Muscular Dystrophy

Allergy/Immune/Rheum: Allergies, Rheumatoid Arthritis, Lupus, Psoriasis

Malignancy: Lung, Breast, Colon, Skin, Brain, Cervical, Ovarian, Prostate, Endometrial, Pancreatic, Throat

Dermatology: Acne, Rosacea, Vitiligo, Eczema

Infectious Diseases: Hepatitis, HIV, AIDS, Herpes, HPV, Tuberculosis, Lyme Disease

Mental Health: Depression, Anxiety, Bipolar, Schizophrenia, Schizoaffective Disorder, Addiction

Name_____ Date of Birth_____

Hospitalizations (not including normal pregnancies) **Year**

1. _____
2. _____
3. _____
4. _____

Surgeries (circle all that apply and list year)

C-section	Gall Bladder Removal	Heart:	Other _____
Hysterectomy	Bladder Suspension	Catheterization	
Ovary/Uterus	Hip Replacement	Angioplasty	
Appendectomy	Knee Replacement	Bypass/Stents	

If female, date of last menstrual period: _____ Age at onset: _____ Freq: _____ days Duration: _____ days

Health Maintenance History (please indicate date of last exam/test)

	Date		Date		Date
Complete Physical Exam		Pneumonia Vaccine		Gardasil (HPV) Vaccine	
Colonoscopy		Shingles Vaccine		Bone Density Scan (DEXA)	
Eye Exam		Tetanus		EKG	
Influenza Vaccine		Chest X-Ray		Rectal Exam	
Mammogram		Dental Exam		PSA Test (Prostate Blood Test)	
Pap Smear		TB Test			

OVER-THE-COUNTER Medications:

Circle any *over the counter* herbs, vitamins, supplements, etc. you are currently taking:

Laxatives	Vitamins	Antacids
Pain Relievers	Energy Drinks/Pills	Weight Loss Pills
Other: _____		

PRESCRIBED Medications (use back of page for additional)

Medication	Dose/Freq	Medication	Dose/Freq

Medication Allergies:

_____

_____

Food Allergies: ☐ no ☐ yes If yes, what foods: _____

Name_____ Date of Birth_____

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)									
Current Health									
Age at death (if applicable)									
Cause of Death									
Conditions (check all that apply)									
Cancer (type)									
Diabetes									
Epilepsy									
Heart Disease									
High Blood Pressure									
Stroke									
Kidney Disease									
Mental Illness									
Alcohol Abuse									
Drug Addiction									
Alzheimer's									
TB									
Athritis									
Glaucoma									
Anemia									