HOMETOWN FAMILY

115 N. Thompson LN.

MEDICAL

Murfreesboro, TN. 37129

Ph. 615-439-6165

Fax. 615-867-3443

FAX:

To:	From: Amber	
Fax:	Pages:	
Phone:	Date:	
Re:	CC:	
Urgent • For Review	Please Comment Please Reply Please Recycle	
Comments:		

FAX DISCLAIMER: The PHI (Protected Health Info) contained in this FAX is CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific health care services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

Hometown Family Medical

115 N. Thompson LN. * Murfreesboro, TN. 37129 615-439-6165

Name: Last	First	M.I	Male	_ Female	
Marital Status: Married					
Address:					
City:	State:		Zip Code:		_
Date of Birth:					
Home Phone: ()					
Employer:		Work Number:			
In Case of Emergency:					
Name of Insurance (Primary and/or	Secondary):				
Person Responsible for Account:					
		ders Date of Birth:			
Relationship to Patient:					
	What is your i	reason for visiting	us today?		
List ALL Medications You	Currently Take:	List ANY Medio	cation <u>ALLER</u> (GIES:	
		4			,

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I authorize the medical treatment, which has been am financially responsible for charges whether or benefits. I authorize the use of this signature on a			ned above, by HOMI vider to release all inf	ETOWN FAMILY N Formation necessary	AED, I acknowledge that I to secure the payment of
Responsible Party Signature	Relati	onship		Date	
Office Staff Only-					An
All Medical History has been reviewed	by:	Date	:		

Hometown Family Medical

115 N. Thompson LN. * Murfreesboro, TN. 37129

615-439-6165

Cancer

Family History: (check all that apply)

Social Habits: (frequency/amount)

Tobacco Use:

Tobacco Ose:	Cancer Asthma
Alcohol Use:	Diabetes Arthritis
	High Blood Pressure
	Heart Disease
Have you ever had any Surgeries:	
List Procedures	Have you ever had a blood to we fire!
	Have you ever had a blood transfusion?
	Could you be pregnant?
	Last menstrual period
	Height
	List any Chronic Health Conditions: (Reasons you take medications)
	Constitution of the content of the c
-	
I hereby acknowledge that I have the	e opportunity to be provided with a copy of the Eggility's Notice of Privacy Practices
apon my request. Taiso certify that a	e opportunity to be provided with a copy of the Facility's Notice of Privacy Practices all my above information is correct to the best of my knowledge. I will not hold my
apon my request. Taiso certify that a	e opportunity to be provided with a copy of the Facility's Notice of Privacy Practices all my above information is correct to the best of my knowledge. I will not hold my aff responsible for any errors or omissions that I may have made in the completion
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doctor or any members of his/her sta	all my above information is correct to the best of my knowledge. I will not hold my aff responsible for any errors or omissions that I may have made in the completion in the completion in the completion on the completion in the

Hometown Family Medical 115 North Thompson Ln. Murfreesboro, TN 37129 (615-439-6165)

Authorization for release of information

Authorize Hometown Family Medical to release to my insurance company, managed care org, state or federal agency, health care financing, third party administration and or workers compensation or its agents any information needed to transmit any or all the above records pertaining to my medical care for payment elimbursement. I acknowledge that faxing my medical records may increase the risk of accidental discloser of my medical information.
Phone messages
l authorize Hometown Family Medical to leave any information concerning my appointment or test results with:
On: (check all that apply)
my answering machine
voicemail
work
home
only with me
request that payment for services furnished to me or on my behalf be paid to Hometown Family Medical.
I understand that I am financially responsible for deductible amounts, co-payments, co-nsurance amounts, non-covered charges and all balances not covered under a contractual write off agreement between Hometown Family Medical and my third party payer. My carrier's failure to pay does not release me from this responsibility. I agree should this account be turned over to collections I will be responsible for all costs incurred.
Signature of responsible party Date

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam				
Name	···		Date of birth	
Sex Age Grade	School		Sport(s)	
			nedicines and supplements (herbal and nutritional) that you are currently	
Do you have any allergies? ☐ Yes ☐ No If yes, p☐ Medicines ☐ Pollens	please identify sp	ecific al	lergy below. ☐ Food ☐ Stinging Insects	
Explain "Yes" answers below. Circle questions you don't kn	ow the answers	to.		
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes No
Has a doctor ever denied or restricted your participation in spor any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	100 100
Do you have any ongoing medical conditions? If so, please iden below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other:	tify ons		27. Have you ever used an inhaler or taken asthma medicine? 28. Is there anyone in your family who has asthma?	
Have you ever spent the night in the hospital?		ļ	29. Were you born without or are you missing a kidney, an eye, a testicle	
4. Have you ever had surgery?		ļ	(males), your spleen, or any other organ?	<u> </u>
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area? 31. Have you had infectious mononucleosis (mono) within the last month?	
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?	ļ <u> </u>
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?	
6. Have you ever had discomfort, pain, tightness, or pressure in you chest during exercise?	ur		34. Have you ever had a head injury or concussion?	
7. Does your heart ever race or skip beats (irregular beats) during	evercise?		35. Have you ever had a hit or blow to the head that caused confusion,	
8. Has a doctor ever told you that you have any heart problems? If	SD.	 	prolonged headache, or memory problems?	
check all that apply:	,		36. Do you have a history of seizure disorder?	
☐ High blood pressure ☐ A heart murmur☐ High cholesterol ☐ A heart infection			37. Do you have headaches with exercise?	
☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	
Has a doctor ever ordered a test for your heart? (For example, E echocardiogram)			Have you ever been unable to move your arms or legs after being hit or falling?	
10. Do you get lightheaded or feel more short of breath than expect during exercise?	ed		40. Have you ever become ill while exercising in the heat?	
11. Have you ever had an unexplained seizure?			41. Do you get frequent muscle cramps when exercising?	
12. Do you get more tired or short of breath more quickly than your	friends		42. Do you or someone in your family have sickle cell trait or disease?	
during exercise?			43. Have you had any problems with your eyes or vision?	ļ
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries? 45. Do you wear glasses or contact lenses?	
 Has any family member or relative died of heart problems or has unexpected or unexplained sudden death before age 50 (includi 	d an		46. Do you wear protective eyewear, such as goggles or a face shield?	
drowning, unexplained car accident, or sudden infant death syn	drome)?		47. Do you worry about your weight?	
 Does anyone in your family have hypertrophic cardiomyopathy, syndrome, arrhythmogenic right yentricular cardiomyopathy. 	Marfan		Are you trying to or has anyone recommended that you gain or lose weight?	
syndrome, short QT syndrome, Brugada syndrome, or catechola polymorphic ventricular tachycardia?	minergic		49. Are you on a special diet or do you avoid certain types of foods?	
15. Does anyone in your family have a heart problem, pacemaker, o	r		50. Have you ever had an eating disorder?	
implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?	
16. Has anyone in your family had unexplained fainting, unexplained	1		FEMALES ONLY	
seizures, or near drowning? BONE AND JOINT QUESTIONS		# 10 T W T W T W T W T W T W T W T W T W T	52. Have you ever had a menstrual period?	
17. Have you ever had an injury to a bone, muscle, ligament, or tend	Yes	No	53. How old were you when you had your first menstrual period?	
that caused you to miss a practice or a game?	ion		54. How many periods have you had in the last 12 months?	
18. Have you ever had any broken or fractured bones or dislocated	oints?		Explain "yes" answers here	
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				
20. Have you ever had a stress fracture?				
21. Have you ever been told that you have or have you had an x-ray instability or atlantoaxial instability? (Down syndrome or dwarfis	m)			
22. Do you regularly use a brace, orthotics, or other assistive device	?			
23. Do you have a bone, muscle, or joint injury that bothers you?				
24. Do any of your joints become painful, swollen, feel warm, or look	red?			
25. Do you have any history of juvenile arthritis or connective tissue				
l hereby state that, to the best of my knowledge, my ans	wers to the abo	ve ques	tions are complete and correct.	
Signature of athlete	Signature of parent/gr	uardian _	Date	
©2010 American Academy of Family Physicians, American Academy	of Pediatrics, Amer	ican Colle	ege of Sports Medicine, American Medical Society for Sports Medicine, American (7 46 !

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM This d

This document is only necessary when the individual has a documented special need.

Date of Exam				a dosamonios oposio	11 11000
Name				Date of birdly	
Sex	Age	Grade	School	Date of birth Sport(s)	
			JCHOOL	Sport(s)	
1. Type of d					
2. Date of d	tion (if available)				
		0000			
5 List the s	oorts you are intere	ease, accident/trauma, other)			
o. cot no s	onta you are micre				
6. Do you re	quiarly use a brace	, assistive device, or prosthetic	•?	Yes No	0
7. Do you us	e any special brace	or assistive device for sports	7		
8. Do you ha	ive any rashes, pres	ssure sores, or any other skin	problems?		
9. Do you ha	ve a hearing loss?	Do you use a hearing aid?			
	ve a visual impairn				
11. Do you us	e any special devic	es for bowel or bladder function	on?		
		omfort when urinating?			
	had autonomic dys				
15. Do you be	ve muscle spasticit	ed with a heat-related (hyperth	ermia) or cold-related (hypothermia) illn	less?	
		sy? s that cannot be controlled by			
Explain "yes"		is that carried be controlled by	medication?		
, , , , , , , , , , , , , , , , , , , ,	2,701707011010				
D		· · · · · · · · · · · · · · · · · · ·			
Please indicat	e if you have ever	had any of the following.			
Adlanta		· ·		Yes No	
Atlantoaxial in	stability On for atlantoaxial ir	note till t			
	ts (more than one)	istaulity			
Easy bleeding	is (more than one)				
Enlarged spies	n				
Hepatitis					
Osteopenia or	osteoporosis				
Difficulty contr	olling bowel				
Difficulty contr	olling bladder				
	ingling in arms or h				
	ingling in legs or fe	et			
Weakness in a					
Weakness in le					
	in coordination				
Spina bifida	in ability to walk				
Latex allergy					
Latter allergy					
Explain "yes" a	inswers here	•			

hereby state t	hat, to the best of	my knowledge my answers	to the above questions are complete		
		,	to the above questions are complete	and correct.	
Signature of athlet			Signature of parent/guardian	Date	
@ 2010 America	n Acadamy of Cami	ilu Physiologo America A	my of Pediatrics, American College of Co		

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

PHYSICIAN RECHINDERS Oneside additional quick processor on recent general features One you feet in any out of the company of	PRINSIDEAR REMINDERS - Do you feel shared to all or curter a six of pressure? - Do you feel shared to all or curter a six of pressure? - Have you ever third uptames, chemic places, and, or op? - Have you ever third uptames, chemic places, and, or op? - Have you ever third uptames, chemic places, and, or op? - Have you ever third uptames, chemic places, and, or op? - Have you ever that an evaluate protein to be you go and not be excellent and the protein to a six of the protein to	Name			Date of birth	
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PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

This form is for summary use in lieu of the physical exam form and health bistons form and many he used when Aliph A concerns are present. history form and may be used when HIPAA concerns are present.

Name	Sex 🗆 M 🗆 F Age	Date of hirth
☐ Cleared for all sports without restriction		Date of Diffit
☐ Cleared for all sports without restriction with recommen	dations for further evaluation or treatment for	
□ Not cleared		
☐ Pending further evaluation		
☐ For any sports		
☐ For certain sports		
Reason		
Recommendations		
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Clinical contraindications to practice and particing	ompleted the preparticipation physical evaluation. ate in the sport(s) as outlined above. A copy of the	The athlete does not present apparent
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(and parents/guardians).	· ·	, , , , , , , , , , , , , , , , , , , ,
Name of physician (print/type)		
Address		Date
Signature of physician		Phone
Signature of physician		, MD or DC
EMERGENCY INFORMATION		
Allergies		
Other information		
oner mornation		
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CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information		
Last Name	First Name	MI
Sex: [] Male [] Female Grade		DOB/
Allergies		
Medications		
Insurance	Policy Number	
Group Number	Insurance Phon	e Number
Emergency Contact Information		
Home Address	(City)	(Zip)
Home Phone		
Mother's Name		
Father's Name		
Another Person to Contact		
Phone Number	Relationship	
	Legal/Parent Consent	
I/We hereby give consent for (athlete	e's name)	to represent
(name of school)	in athletics	realizing that such activity involves
potential for injury. I/vve acknowledg	e that even with the best coaching.	the most advanced equipment and
strict observation of the rules, injuries	s are still possible. On rare occasi	ons these injuries are severe and
result iii disability, paralysis, and e	even death. I/We further grant peri	mission to the school and TSSAA
ns physicians, athletic trainers, an	d/or EMT to render aid, treatment.	medical or surgical care doomed
reasonably necessary to the heal	th and well being of the studen	t athlete named above during or
resulting it of the participation in athle	etics. By the execution of this conse	ent the student athlete named above
and mismer parent/guardian(s) do her	eby consent to screening, examination	on and testing of the student athlete
during the course of the pre-participa	tion examination by those performing	the evaluation, and to the taking of
medical history information and the re	ecording of that history and the findi	nas and comments portaining to the
student athlete on the forms attached legal Guardian. I/Wa romain fully r	nereto by those practitioners perfor	rming the examination. As parent or
legal Guardian, I/We remain fully repersonal actions taken by the above	esponsible for any legal responsi e named student athlete.	bility which may result from any
Signature of Athlete	Signature of Parent/Guardian	Date