TENNESSEE PLATEAU ONCOLOGY

DIRK DAVIDSON M.D.

33 WEST ADAMS ST

CROSSVILLE, TN 38555

OFFICE: 931/484-7596 FAX: 931/484-7597

PATIENT NAME: _____

DATE OF BIRTH: _____ SS# _____

IF CHILD, PARENTS NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE # _____ CELL # _____

E-MAIL ADDRESS: _____

ADVANCED DIRECTIVES: DO YOU HAVE: DURABLE POWER OF ATTORNEY (FOR HEALTH CARE) Y____ N____
IF YES, LIST NAME: _____ LIVING WILL: Y_____ N_____ DNR: Y_____ N_____

SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S SS# _____

SPOUSE'S TELEPHONE # _____ CELL # _____

PHARMACY NAME: _____ PHONE # _____

ALLERGIES TO MEDICATIONS: _____

DIABETIC: YES_____ NO_____

REFERRING PHYSICIAN NAME: _____ PHONE# _____

FAMILY PHYSICIAN NAME: _____ PHONE # _____

EMPLOYED: _____ RETIRED: _____ DISABLED: _____

EMPLOYER/PHONE NUMBER: _____

TENNESSEE PLATEAU ONCOLOGY

Authorization for Release of Information
Phone: 931-484-7596 Fax: 931-484-7597

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER

DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____ CELL: _____

E-MAIL ADDRESS: _____

DOCTOR WE CAN OBTAIN/RELEASE RECORDS FROM/TO:

_____ PHONE: _____

_____ PHONE: _____

_____ PHONE: _____

TO RELEASE INFORMATION FROM MY MEDICAL RECORD AS INDICATED BELOW FOR:

PURPOSE OF DISCLOSURE	INFORMATION TO BE RELEASED	I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION
CHANGING PHYSICIANS	HISTORY AND PHYSICAL EXAM	SUBSTANCE ABUSE (INCLUDING ALCOHOL DRUG)
▪ SCHOOL	PROGRESS NOTES	MENTAL HEALTH (INCLUDING PSYCHOTHERAPY NOTES)
▪ CONSULTATION/SECOND	LAB REPORTS	HIV RELATED INFORMATION
▪ CONTINUING CARE	X-RAY REPORTS	(AIDS RELATED TESTING)
▪ WORKERS COMPENSATION	PATHOLOGY	
▪ LEGAL	OTHER (SPECIFIC)_____	
▪ OTHER	_____	

1. I understand that this authorization will expire in 1 year after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Federal privacy regulations.
4. I understand that if I am being requested to release this information to Tennessee Plateau Oncology for the purpose of continued care.
   a. By authorizing this release of information, my health care and payment for my health care will be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it .
   c. I have been informed that Tennessee Plateau Oncology will/will not receive financial or in-kind compensation in exchange for using or disclosing the health information describe above.

Signature of Patient Date Parent Legal Guardian Date

Witness Date

PATIENT NAME: _____

D.O.B.: _____

MEDICATION ALLERGIES: _____

_____

DIABETIC: YES: _____ NO: _____

MEDICATION LIST

MEDICATION NAME	**MEDICATION:** DOSAGE/STRENGTH	**FREQUENCY:** (HOW MANY PILLS/HOW OFTEN)

MEDICARE QUESTIONNAIRE

Patient Name & Signature_____

Date of Birth:_____

Completed By:_____

Date:_____

1. Do You have End Stage Renal Disease: Yes No
2. Have you received maintenance dialysis treatments? Yes No
   A: If yes, what was the beginning date of your treatment ?_____
3. Have you received a kidney transplant? Yes No
   A: If yes what was the date of your transplant?_____
4. Are you currently disabled? Yes No
   A:If yes describe disability:_____
   Disability date:_____
5. Do you have a Fee Service Card from the Department of Veteran Affairs? Yes No
6. Are the Services to be paid by a program such as a Research Grant? Yes No
7. Are you currently working: Full time/Part time Retired (Circle one)
   A: If retired, Retirement Date:_____
   B:If you are married, is your spouse currently working? Full time/Part time
   If retired, retirement date:_____
8. Are you covered by an Employer Group Health Plan through your , your spouse or other family members current or former employment? Yes No
   A: If yes, Insurance Plan_____
   B: Is the plan secondary to Medicare? Yes No
   C: A Single Employer Plan? Yes No
   D: A large Group Health Plan? Yes No
   E: Number of Employees? 1-19, 20-99, 100 or more?
   F: If Multi-Employer LGHP do all employers employ less than 100? Yes No
9. Is this a work related injury or illness? Yes No
   A: Are you entitled to Black Lung Medical Benefits? Yes No
   If yes describe injury/illness_____
   Date:_____Insurance Plan:_____
10. Is this injury/illness related to an auto accident or an illness/injury for which another party could be held responsible? Yes No
    If yes describe injury/illness_____
    Date:_____Insurance Plan:_____