



Moses A. Swauncy, MD

Lucinda Motley, FNP-C

Whitney Cochran, FNP-BC

Lorrie Richardson, FNP-C

Today's Date: _____

Patient Name: _____ DOB: _____ Gender: M F

Address: _____

City: _____ State: _____ Zip: _____ Social Security # _____

Marital Status: Single/Married/Divorced/ Widow(er) Phone #: _____ Alternate #: _____

Email Address: _____ Can we send you emails? YES or NO

How did you hear about us? _____

Employer/School: _____ Phone #: _____

Address: _____ Occupation: _____

Primary Insurance:

Subscriber's Name (as it appears on card): _____

Subscriber's DOB: _____ Subscriber's Social Security #: _____

Relation to patient (if other than self): _____ Subscriber's Employer: _____

Responsible party for minor child:

Name: _____ DOB _____ Relation to child: _____

Social Security # _____ Phone # _____ Alternate: _____

Emergency Contact:

Name: _____ Relation to patient: _____

Phone #: _____ Alternate #: _____

- Social Security Authorization: I certify that the information given me in applying for payment under the title XIX of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any information needed for claims made for Medicare, Medicaid, or other third party payments. I request that payments of authorized benefits be made directly to Signature Health & Wellness or its agent on my behalf.
- I hereby authorize Signature Health & Wellness to examine me and render treatment as deemed necessary.
- I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature: _____ Date: _____

6001 Jackson Square Blvd., Ste 100
LaVergne, TN 37086
Phone: 615-793-9900
Fax 615-793-9990

925 S. Church St., Ste A300
Murfreesboro, TN 37130
Phone: 615-988-2700
Fax 615-217-2749

589 Stewarts Ferry Pk., Ste A
Nashville, TN 37214
Phone: 615-457-3632
Fax 615-457-3364

NAME: _____ ALLERGIES: _____

PLEASE LIST MEDICATIONS BELOW

Past surgical history: _____

PLEASE CHECK THE FOLLOWING:

DISEASE	YOU	FAMILY MEMBER	DISEASE	YOU	FAMILY MEMBER
Heart Attack			Stroke		
Emphysema			Bleeding Disorder		
Cancer			Diabetes		
Tuberculosis			Thyroid Disorder		
Kidney Disorder			Liver Disorder		
Mental Health			High Blood Pressure		
High Cholesterol			Females Only:	Number of:	
Prostate Problem			Pregnancies		
Skin Disorder			Premature Births		
Headaches			Abortions		
Stomach Disorder			Ectopic		
Colon Disorder			Miscarriages		
Tobacco Use			Multiple Births		
Asthma			Living Children		

LIVING WILL/ADVANCE DIRECTIVE: ___ YES ___ NO

IMMUNIZATIONS: UP-TO-DATE _____ YES _____ NO

DO WE HAVE A COPY? _____ YES _____ NO

LAST TETANUS SHOT: _____ **FLU SHOT:** _____ **PNEUMONIA SHOT:** _____

LAST EYE EXAM: _____



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Authorization for Release of Medical Records

I hereby authorize:

Physician/Facility Name: _____

Address: _____

Phone #: _____ Fax #: _____

To release any and all medicals records including information regarding alcohol/drug abuse, lab results, radiology, progress notes, psychiatric, etc... To: (please check which location)

Signature Health & Wellness

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Nashville, TN 37214
Phone: 615-457-3632
Fax 615-457-3364

Patient Name: _____ DOB: _____

I understand that I may revoke this authorization at any time, unless an earlier date is specified. This authorization will automatically expire 12 months after the date signed below.

Signature: _____ Date: _____

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