William Van Bingham, MD
6005 Park Ave., Suite 803 Memphis, TN 38119

Date________________________

Patient Name: ____ Date of Birth: _____/_____/______

Sex: M☐ F☐ Marital Status: S☐ M☐ D☐ W☐ S.S. #: ______-_____-______ Race: ________________

Address:____

City: _____________________________________ State: _______________ Zip: ________________

Home Phone: _____________________ Cell: _________________________ Work: ____________________

Email address: ____

Best number to contact you: Home ☐ Cell ☐ Work ☐ May we leave messages: YES☐ NO☐

Employment Status: FT ☐ P ☐ Retired ☐ Disabled ☐ Unemployed ☐

Employer Name and Address: ____

Emergency Contact: ______________________Phone #: _________________Relationship: _______________

Were you referred, if yes by whom: ____

Primary Care Physician: ____

Cardiologist or any other physicians: ____

Is there someone we may discuss your test results/medical treatment with? YES ☐ NO☐

If yes, who? ____

Insurance Information

Primary Insurance: _______________________________________ Id #: _________________________________

Insured Name: ___________________________ Relationship to Patient: _______________ DOB: ___________

Secondary Insurance: ____________________________________ Id #: __________________________________

Insured Name: ___________________________ Relationship to Patient: _______________ DOB: ___________

PRESCRIPTIONS WILL BE SENT ELECTRONICALLY, PLEASE PROVIDE PHARMACY INFO:

Name of Pharmacy: ________________________________ Phone/Address: ______________________________

William Van Bingham, MD, PC

Patient Name: ____ **Date:** ____________________________

Social History

Please answer all questions.

Do you or have you ever smoked? Currently ☐ formerly ☐ never ☐

If currently how much? _______________ since what age? ____________

Alcohol intake? None ☐ occasionally ☐ moderately ☐ heavy ☐

Caffeine intake (coke, tea, coffee) none ☐ occasionally ☐ moderately ☐ heavy ☐

Any recreational drugs? Yes ☐ No ☐ if yes: ________________________________

Deaf or serious difficulty hearing? Yes ☐ No ☐

Blind or serious difficulty seeing? Yes ☐ No ☐

Difficulty concentrating, remembering, or making decisions? Yes ☐ No ☐

Difficulty walking or climbing stairs? Yes ☐ No ☐

Review of Systems

Do you now or have you recently had any problems related to the following systems?

Constitutional

Fever	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Excessive headaches	☐ Yes	☐ No

Eyes

Dry	☐ Yes	☐ No
Irritation	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No

Ear/Nose/Throat/Mouth

Difficulty Hearing	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No

Cardiovascular

Chest pain on exertion	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Respiratory

Frequent cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Musculoskeletal

Muscle aches	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No

Integumentary

Rash	☐ Yes	☐ No
Persistent itch	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No

Neurological

Numbness/tingling	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Thoughts of suicide	☐ Yes	☐ No
Are you generally satisfied With your life?	☐ Yes	☐ No

Endocrine

Fatigue/tired	☐ Yes	☐ No
Increased thirst	☐ Yes	☐ No
Cold intolerance	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen glands	☐ Yes	☐ No
Blood clotting problems	☐ Yes	☐ No
Easily bruised	☐ Yes	☐ No

Allergic/Immunologic

Hives	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No
Frequent sneezing	☐ Yes	☐ No

Patient History

Name: ____ Date: ______________________________

Chief Complaint: (What is the main reason for your visit today? Describe your problem in detail.)

____

How long have you had this problem? ____

Have any tests been done for this problem: (please check) Lab ☐ X-rays ☐ CT scan ☐ Ultra sound ☐ MRI ☐

If yes, where were the tests done: Baptist ☐ Methodist ☐ St. Francis ☐ other: _________________

Are you on any medications: Yes ☐ or No ☐ (If yes, please list all medicines, strengths, and directions.)

____

____

____

____

Do you take a daily Aspirin? Yes ☐ or No ☐

Are you allergic to anything: Yes ☐ or No ☐ If yes, please list all?

____

Personal Medical History

Please check yes or no to the following:

Condition			Condition		
Arthritis	☐Yes	☐No	Heart Disease	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Murmur	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	Hematuria	☐Yes	☐No
Blood Clots	☐Yes	☐No	Hepatitis	☐Yes	☐No
Cancer	☐Yes	☐No	Hernia	☐Yes	☐No
Cancer, bladder	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Cancer, kidney	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Cancer, prostate	☐Yes	☐No	Kidney stones	☐Yes	☐No
COPD	☐Yes	☐No	Migraine Headaches	☐Yes	☐No
Cirrhosis of liver	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No
Congestive heart failure	☐Yes	☐No	Renal Failure	☐Yes	☐No
Diabetes	☐Yes	☐No	Stroke	☐Yes	☐No
HIV	☐Yes	☐No	Sleep Apnea	☐Yes	☐No

Please list any other health problems: ____

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Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Surgical History :

Name: ____ Date: ___________________________

Please check yes or no to the following

Appendectomy	☐ Yes	☐ No	if yes, what year: __________
Arm surgery	☐ Yes	☐ No	if yes, what year: __________
Back surgery	☐ Yes	☐ No	if yes, what year: __________
Bladder surgery	☐ Yes	☐ No	if yes, what year: __________
Brachytherapy	☐ Yes	☐ No	if yes, what year: __________
Breast surgery	☐ Yes	☐ No	if yes, what year: __________
C-Section	☐ Yes	☐ No	if yes, what year: __________
Eye surgery	☐ Yes	☐ No	if yes, what year: __________
Foot surgery	☐ Yes	☐ No	if yes, what year: __________
Gallbladder surgery	☐ Yes	☐ No	if yes, what year: __________
Head/neck surgery	☐ Yes	☐ No	if yes, what year: __________
Heart surgery	☐ Yes	☐ No	if yes, what year: __________
Hernia	☐ Yes	☐ No	if yes, what year: __________
Hysterectomy	☐ Yes	☐ No	if yes, what year: __________
Kidney surgery	☐ Yes	☐ No	if yes, what year: __________
Kidney stones	☐ Yes	☐ No	if yes, what year: __________
Knee surgery	☐ Yes	☐ No	if yes, what year: __________
Prostate surgery	☐ Yes	☐ No	if yes, what year: __________
Sinus surgery	☐ Yes	☐ No	if yes, what year: __________
Tonsillectomy	☐ Yes	☐ No	if yes, what year: __________
Vasectomy	☐ Yes	☐ No	if yes, what year: __________

Please list any other surgeries you have had not listed above:

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FAMILY MEDICAL HISTORY:

DOES YOUR FAMILY MEMBER HAVE OR EVER HAD ANY OF THE FOLLOWING:

Cancer of Prostate	☐Yes☐No	if yes whom?☐Father,☐Brother ☐ other relative ___________________
Breast cancer	☐Yes☐No	if yes whom?☐ Mother,☐ Father,☐Brother,☐ Sister
Ovarian cancer	☐Yes☐No	if yes whom?☐ Mother,☐ Sister
Pancreatic cancer	☐Yes☐No	if yes whom?☐ Mother,☐ Father,☐Brother,☐ Sister
Other cancer______________________		if yes whom?☐ Mother,☐ Father,☐ Brother,☐ Sister
Diabetes:	☐ Yes☐No	if yes whom?☐Mother,☐ Father,☐Brother,☐Sister
Heart Disease:	☐ Yes☐No	if yes whom?☐Mother,☐ Father,☐Brother,☐Sister
High Blood Pressure:	☐Yes ☐No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Kidney Disease:	☐Yes ☐No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Alcoholism/Addiction:	☐Yes ☐No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Alzheimer's disease:	☐ Yes☐No	if yes whom?☐Mother,☐ Father,☐Brother,☐Sister
Lung Disease:	☐ Yes☐No	if yes whom?☐ Mother,☐ Father,☐Brother,☐ Sister
Complete Deafness:	☐ Yes☐No	if yes whom?☐Mother,☐ Father,☐Brother,☐Sister
Liver Disease:	☐ Yes☐ No	if yes whom?☐Mother,☐ Father,☐Brother,☐Sister
Stomach Disorder:	☐ Yes☐ No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Emphysema:	☐ Yes☐ No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Mental Disorder:	☐ Yes☐ No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister
Seizure Disorder:	☐ Yes☐No	if yes whom?☐ Mother,☐ Father,☐ Brother,☐ Sister
Sudden Death:	☐Yes ☐No	if yes whom? ☐Mother,☐Father, ☐Brother, ☐Sister

Other problems not listed above?

____

____

At time of appointment you will be responsible for any co-pay, deductible, co-insurance, or patient balance. Please fill out all forms completely, incomplete forms may delay your appointment. Thank-You

William Van Bingham M.D., P.C.

Patient name: ________________________________

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy our office extends to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. All copays and deductible amounts are required to be paid at the time services are rendered unless a prior agreement has been initiated. A 24-hour cancellation notice is required to avoid a $25.00 charge.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to my physician for benefits due to me for his services. I understand that I am financially responsible for charges not covered by this insurance.
RELEASE OF INFORMATION: I hereby authorize the physician to release any information required to process any insurance claim.
AGREEMENT: In the event of default, I agree to pay all costs of collection including all reasonable attorney fees and court costs.
If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask.

I have read and understand this explanation of the payment policy of William Van Bingham, M.D., P.C.

SIGNATURE____ DATE__________________________________

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<u>Medicare patients</u> with secondary insurances: I request that payment of the authorized secondary benefits be made on my behalf to William Van Bingham, M.D., P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to be released to my secondary insurer to determine these benefits. This authorization is in effect until I choose to revoke it.

SIGNATURE____ DATE__________________________________

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NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to protect the privacy of your information, provide this Notice about our information practices and follow the information practices that are described in this Notice.

I acknowledge that I have been made aware of the Notice of Privacy Practices for William Van Bingham, M.D., P.C. and that a copy of the Notice is available for me to review at any time. I also acknowledge that I have read and understand the Notice and have been provided with an opportunity to ask questions.

SIGNATURE____DATE__________________________________

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RELEASE OF MEDICATION HISTORY

This Release of Medication History will allow William Van Bingham, M.D., P.C. to share or retrieve your medication history electronically with the secure PBM's (Pharmacy Benefit Managers) via SureScripts.

SIGNATURE____DATE__________________________________

William Van Bingham, M.D., P.C.

PATIENT ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY FOR OUTSIDE SERVICES

We would like to welcome you to our office and are happy that you have chosen us for your health care needs. Our goal is to provide the best possible medical care for you. In order to meet this goal, there may be certain diagnostic tests and/or procedures that need to be performed that require an “outside” health care provider’s services. By way of example, certain blood and/or urine samples may need to be sent to an outside laboratory for processing. Other diagnostic tests may require an outside physician’s professional services such as a pathologist’s interpretation/report on a biopsy sample or a radiologist’s interpretation of an x-ray or other diagnostic imaging study. It also is possible that certain tests or procedures may be recommended and ordered by Dr. Bingham which require the facilities at a hospital or surgery center. The foregoing are examples of “outside” health services. These examples are not meant to be all inclusive and there may be other “outside” health care services that are different from the examples provided.

I acknowledge that I may receive a bill from a specialist’s office, laboratory or hospital if any tests, examinations or procedures are sent out or conducted outside of this office. I acknowledge that I will be responsible for the timely payment of any bill that I may receive from any physician, specialist’s office, laboratory or hospital for any tests, examinations or procedures that are referred out or conducted outside of this office. I understand that William Bingham, M.D. and William Bingham, M.D., P.C. are not responsible for payment to any outside service providers.

I acknowledge that I have read and understand the contents of this Acknowledgment of Financial Responsibilities for Outside Services.

__________________________________ ______________________
Please Print Patient’s First and Last Name Date of Birth

____
Signature of Patient
(Parent or Guardian if Patient is a Minor)

Date: ____________________________________

____
Relationship of Patient Representative to Patient (if patient is a minor or adult who is unable to sign this form)

MEDICAL RECORD RELEASE FORM

WILLAM VAN BINGHAM, MD, FACS
6005 PARK AVENUE
SUITE 803
MEMPHIS, TN 38119
P: 901-683-0642 F: 901-881-6011

______________________________ ______________________
PATIENT NAME DATE OF BIRTH

____
SOCIAL SECURITY #

____
ADDRESS

****

I HEARBY AUTHORIZE THE BELOW LISTED ENTITY TO RELEASE MY MEDICAL INFORMATION TO WILLIAM VAN BINGHAM, MD:

OFFICE NAME: ____

DOCTOR: ____

ADDRESS: ____

____

PHONE# ________________________ FAX# __________________________

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MEDICAL INFROMATION REQUESTED (CHECK BOX BELOW)

☐ ALL RECORDS

☐ SPECIFIC RECORDS FROM ____________ TO __________

☐ LABS

☐ RADIOLOGY REPORTS (X-RAY, MAMMOGRAPHY, ULTRASOUND, CT, MRI, ETC)

______________________________ ______________________
PATIENT SIGNATURE DATE