Donald A. Lakatosh, M.D.
11560 Chapman Highway, Suite 1
Seymour, TN 37865
(865) 577-1914

Last Name:	**Sex:** M/F
First Name:	**Home Phone:**
M. Name/Suffix:	**Work Phone:**
Prev Last Name:	**Mobile Phone:**
DOB: ___/___/___	**Email:**
SSN: ____-____-____	**Contact Preference (for practice staff use):**
Address:	
Zip:	**Marital Status:** Married/ Single/ Divorced/ Widowed
City:	
State:	
Race: African American/ White/ Asian/ Native American/ Other:	**Language:** English/ Spanish/ Other:
	Ethnicity: Hispanic/Latino Not Hispanic or Latino/ Other:
How did you hear about us? _____	
Primary Care Provider? _____	

Primary Insurance Company:	**Policy #:**
Address:	**Group #:**
	Phone: ( ) -
Whose name is insurance under (Guarantor):	
Relationship of insured to patient: Self/ Spouse/ Parent/ Legal Guardian/ Other _____	
Guarantor's DOB: ___/___/___	**Guarantor's SSN:** ____-___-____
Secondary Insurance Company:	**Policy#:**
Address:	**Group#:**
	Phone: ( ) -
Emergency Contact:	
Name:	**Phone:** ( ) -
Address:	**Cell Phone:** ( ) -
Relationship to you:	

Reason for visit:

Donald A Lakatosh, M.D. 11560 Chapman Highway, Suite 1, Seymour, Tennessee 37865
Tel (865) 577-1714 e-mail: physicalmedicine@dalakatosh.com or visit us at www.drlakatosh.com

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FINANCIAL POLICY

Thank you for choosing Donald A. Lakatosh, M.D, to meet your specialized medical needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy, of which require you to read and sign.

PAYMENT IN FULL IS DUE AT TIME OF SERVICE

NOTICE TO PATIENTS: There will be no video or audio taping of any kind without prior written consent from Donald A. Lakatosh, M.D.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are 3rd party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services under your health insurance. You, as the patient, ultimately are responsible for payment of all services provided by our facility. Our billing department is available to discuss any questions you may have regarding your insurance or your account at (865) 577-1914, Monday through Friday 8:00am – 4:30pm.

REFERAL FORMS: It is imperative that if you are covered under a health insurance plan that requires referrals, you need to contact your Primary Care Physician (PCP) and have their office make a referral to us prior to your appointment. The referrals will authorize you to see us, and your claim to be processed for payment. If your plan requires a referral to obtain full benefits and you incur an out-of-pocket penalty by not supplying one, you will be responsible for the non-covered amounts connected to that visit.

SELF-PAY PATIENTS: If you are non-covered by insurance, you will need to speak to the Office Manager at (865) 577-1914. It is imperative that you call and speak to the Office Manager who may be able to offer you additional information.

If an account becomes past due, necessary actions will be taken to recover the account balance due. If the account is sent to a collection agency, (twenty) 20% will be added to the final balance

I understand and agree to this financial policy.

_____ Date: _____

Signature of Patient or Responsible Party

_____ Date: _____

Signature of Staff from Dr. Lakatosh's Office

CONSENT TO RELEASE INFORMATION

I, _____, give the Physician and office staff of Donald A. Lakatosh, M.D., p.a., me permission to discuss my health information (medical, financial, etc.) with the following people that I have listed below. This is an independent consent form, which I may revoke this at anytime in writing. I also have been presented with a copy of Donald A. Lakatosh M.D., privacy policy.

PLEASE LIST FAMILY MEMBERS &/OR FRIENDS ONLY

WITH: _____WHO IS: _____ AT PH#:_____

(RELATIONSHIP)

WITH: _____WHO IS: _____ AT PH#:_____

(RELATIONSHIP)

_____ Date: _____

Signature of Patient or Responsible Party

_____ Date: _____

Signature of Staff from Dr. Lakatosh's Office

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Patient Name:_____Date:_____

Pharmacy Name: **Phone:**

Allergies/Adverse Reactions:

Drugs/Allergy:	Reaction:	Onset Date:	Notes:

Medicine:

Name:	Strength:	Written by:

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SOCIAL HISTORY

Circle or fill-in

What do you walk with?	Cane, walker, wheel chair, none
Education:	Less than 8th , 8, 9, 10, 11, 12, 2 year college, 4 year college, post-graduate
Occupation:	_____
Live alone or with others?	Alone, With others
Single or multi-level home?	Single, Multi-level
Smoking – How much?	Never, Former, 1PPW, 2PPW, 1/4PPd, 1PPD, 2PPD, 3+PPD
Tobacco-years of use?	_____
Alcohol intake:	None, Occasional, Moderate, Heavy
Caffeine intake:	None, Occasional, Moderate, Heavy
Illicit drugs:	_____
Exercise level:	None, Occasional, Moderate, Heavy
Sporting activities:	_____
Number of children:	0, 1, 2, 3, 4, 5, 6, 7, 8, 9+
Hand Dominance:	Right, Left
Are you currently employed?	Yes, No
Employer:	_____
Work related injury?	Yes, No _____
Auto related injury?	Yes, No _____
If injured, is litigation ongoing?	Yes, No _____
Able to care for self:	Yes, No _____
Diet:	Regular, Vegetarian, Vegan, Gluten Free, Specific Carbohydrate, Cardiac
Have you seen other doctors for this problem?	Yes, No_____
Have you had a previous MRI/Xray?	Yes, No_____

Patient Name:_____Date:_____

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Patient Name:_____Date:_____

Past Medical History: (circle one)		Notes:
Anemia	yes / no	_____
Anxiety Disorder	yes / no	_____
Arthritis	yes / no	
Asthma	yes / no	_____
Bleeding Disorder	yes / no	_____
Blood Clots	yes / no	_____
Cancer	yes / no	_____
Depression	yes / no	_____
Diabetes	yes / no	_____
GERD/Reflux	yes / no	_____
Gout	yes / no	_____
HIV or AIDS	yes / no	_____
Heart Problem	yes / no	_____
Hepatitis	yes / no	_____
Hypertension	yes / no	_____
Joint Pain	yes / no	_____
Kidney Disease	yes / no	_____
Leg or Foot Ulcers	yes / no	_____
Liver Disease	yes / no	_____
Lung Disease	yes / no	_____
Migraines	yes / no	_____
Muscle Pain	yes / no	_____
Osteoporosis	yes / no	_____
Pacemaker	yes / no	_____
Rheumatoid Arthritis	yes / no	_____
Seizures/Epilepsy	yes / no	_____
Stroke	yes / no	_____
Thyroid Problems	yes / no	_____
Tuberculosis	yes / no	_____
Ulcers	yes / no	_____
Urinary Tract Infection	yes / no	_____

Other: _____

Notes:

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Patient Name:_____Date:_____

Review of Systems: (circle if positive)									
Constitutional:	Fever	Night sweats	Weight gain (_____lbs)	Weight loss (_____lbs)	Exercise intolerance	Addt'l notes:			
Eyes:	Dry eyes	Irritation	Vision change	Addt'l notes:					
ENMT:	Difficulty hearing	Ear pain	Addt'l notes:						
Nose:	Frequent nosebleeds	Nose/sinus problems	Addt'l notes:						
Mouth/Throat:	Sore Throat	Bleeding gums	Snoring	Dry mouth	Oral abnormality	Mouth Ulcer	Teeth	Mouth breathing	Addt'l notes:
Cardiovascular:	Chest pain on exertion	Arm pain on exertion	Shortness of breath when walking	Shortness of breath when lying down	Palpitations	Known heart murmur		Light-headed on standing	Addt'l notes:
Respiratory:	Cough	Wheezing	Shortness of breath	Coughing up blood	Sleep apnea	Addt'l notes:			
Gastrointestinal:	Abdominal pain	Vomiting	Change in appetite	Black or tarry stools	Frequent diarrhea	Vomiting blood		Addt'l notes:	
Genitourinary:	Urinary loss of control	Difficulty urinating	Increased urinary frequency	Hemaaturia	Incomplete emptying			Addt'l notes:	
Musculoskeletal:	Muscle aches	Muscle weakness	Arthralgias/ joint pain	Back pain	Swelling in the extremities			Addt'l notes:	
Integumentary:	Abnormal	Jaundice	Rash	Itching	Dry skin	Growths/legions		Addt'l notes:	
Neurologic:	Dizziness	Migraines Frequent or severe headaches	Loss of consciousness	Weakness	Numbness	Seizures	Restless legs	Addt'l notes:	
Psychiatric:	Alcohol abuse	Depression	Sleep disturbances	Restless sleep	Feeling unsafe in relationship		Addt'l notes:		
Endocrine	Fatigue	Increased thirst	Hair loss	Increased hair growth	Cold intolerance		Addt'l notes:		
Hematologic/ Lymphatic:	Swollen glands	Easy bruising	Excessive bleeding	Addt'l notes:					
Allergy/ Immunologic	No hives	Runny nose	Sinus pressure	Itching	Hives	Frequent sneezing	Addt'l notes		
Notes:									

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FAMILY HISTORY: Do your immediate relatives have any of the following medical conditions?

Age / Alive / Deceased — Conditions / Cause of Death If Deceased

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Aunts: _____

Uncles: _____

Cancer_____	Bleeding Problems	Arthritis
Hemophilia	Kidney disease	Sickle cell Anemia
High Blood Pressure	Heart disease	Breathing problems
Tuberculosis	Any other diseases: _____	

SURGICAL HISTORY: What operations have you had and give dates please.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Patient, Guardian, or Personal Representative: _____

Please print name signed: _____ Date: _____

Signature of Dr. Lakatosh: _____ Date: _____

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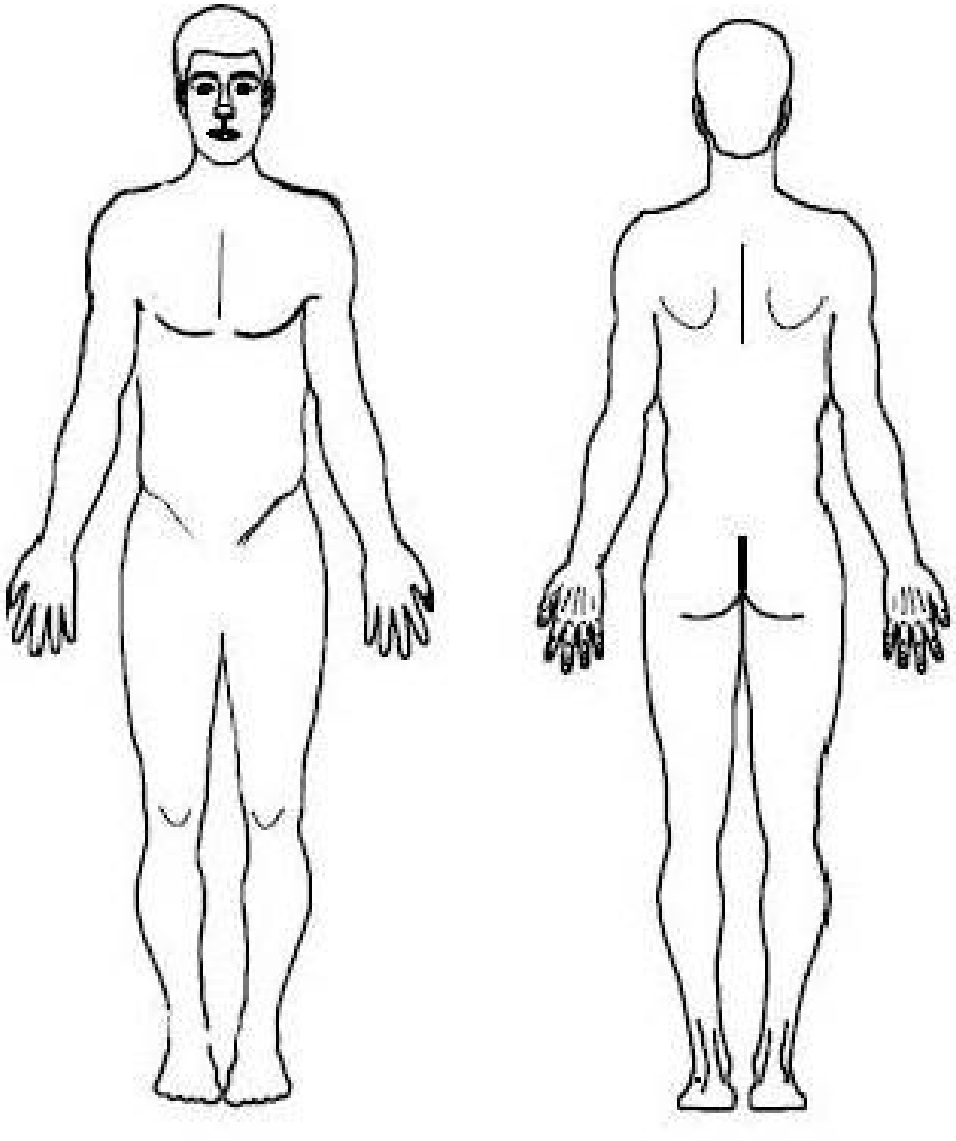
Pain Drawing

Patient Name: _____ Date: _____

Mark the area on your body where you feel the described sensations.

Numbness	------	Increased Sensitivity	000
Constant Ach	XXX	Sharp Twinge	////



No Pain _____ Pain at its' Worst

Mark on the above line the pain you have now and your pain at its' worst

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Donald A. Lakatosh, M.D.

Address: 11560 Chapman Highway, Suite 1

City: Seymour State: TN Zip Code: 37865

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION HAS NO EXPIRATION AFTER IT IS SIGNED.