

## Patient Visit Form

Today's Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please take a moment to answer the questions below in order to best use the time spent today with your provider.

### Reason for today's visit

**Indicate only one of the following:**

\_\_\_\_\_ **New Patient**

\_\_\_\_\_ **Annual Physical exam/preventive medicine**

\_\_\_\_\_ **Follow up visit** for an already established medical problem

\_\_\_\_\_ **Problem** I wish to be evaluated/treated for by the doctor

What concerns do you want to be sure to discuss at today's appointment? \_\_\_\_\_

\_\_\_\_\_

What symptoms do you want your provider to be aware of? \_\_\_\_\_

\_\_\_\_\_

What providers (Hospital, Emergency Room, Urgent Care Clinic, Specialist, etc.) have you seen since your last visit?

\_\_\_\_\_

\_\_\_\_\_

Please list all allergies: \_\_\_\_\_

\_\_\_\_\_

**If you are scheduled for the following, please indicate which one (s).**

\_\_\_\_\_ Refill of medication(s)

\_\_\_\_\_ Protime

\_\_\_\_\_ DEXA

\_\_\_\_\_ Lab work

\_\_\_\_\_ Ultrasound, Echo,  
Holter stress test

\_\_\_\_\_ Completion of forms

\_\_\_\_\_ Urine test-symptoms: \_\_\_\_\_

\_\_\_\_\_ OTHER \_\_\_\_\_

**I understand I will be responsible for any charges that my insurance does not cover.**

Tennessee Law requires that we ask, "**Do you have a living will**"?

\_\_\_ Yes

\_\_\_ No

If no, do you want information on a living will?

\_\_\_ Yes

\_\_\_ No

**Emergency Contact:** Name and Number: \_\_\_\_\_

**Signature:** \_\_\_\_\_