Franklin Gastroenterology, PLLC
Wilmot C. Burch, Jr., MD
James R. Davenport, MD, Ph.D
Rachel Wagner, APN
740 Cool Springs Blvd., Suite 210
Franklin, TN 37067
615-771-8786

We would like to welcome you to Franklin Gastroenterology!

Your appointment date and time is:

Please arrive **15 to 30 minutes** before your appointment time to allow time to finish the appropriate paperwork and to create a chart for your visit. Please bring you insurance card, picture ID, as well as, your medication list. This visit is a consultation or initial exam, as a rule there are no procedures done the first visit. **If your insurance requires that you have a referral prior to seeing a specialist, you will need to call your primary care physician to have that referral sent to us. We will need to have this referral prior to your scheduled appointment.**

Please be advised, depending on your insurance plan, a copay will be collected at the time of service. If your insurance plan requires a referral you will need to verify with your Primary Care Physician that it has in fact been submitted and that a copy has been sent to our office prior to your scheduled appointment. For any NEW self-pay patients, there is a minimum of $100.00, which will be collected at the time of service. We will apply a self-pay discount to that visit and if there is a remaining balance we will issue a statement. For any ESTABLISHED self-pay patients, there is a minimum of $50.00, which will be collected at the time of service. Again, a self-pay discount will be applied to the visit and if there is a remaining balance you will be issued a statement.

Please complete these forms in their entirety, as we will collect them from you at the time of service.

We will make every attempt to see you on time, acknowledging the fact that emergent visits do occur.

Franklin Gastroenterology does respect your time. Please respect ours as well. If you are unable to make your appointment please call our office at least 24 hours in advance as there are other people who would be able to use that time. Failure to contact the office within a timely manner will result in a $50.00 No Show Fee for new patients and a $25.00 No Show Fee for established patients.

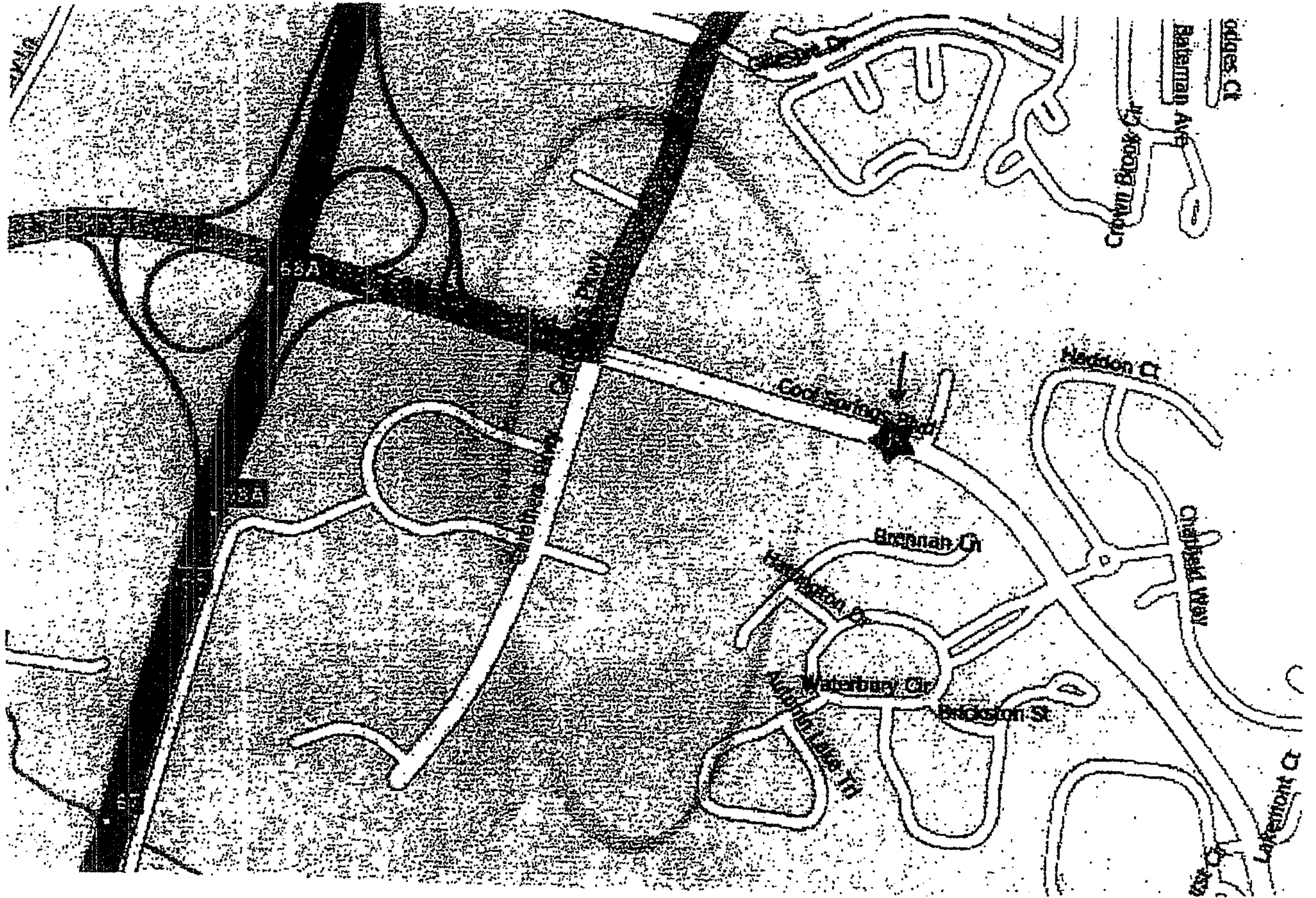
Thank you and we look forward to participating in your medical care.

Sincerely,

Franklin Gastroenterology

FRANKLIN GASTROENTEROLOGY; PLLC

740 COOL SPRINGS BLVD. STE 210
FRANKLIN, TN. 37067
PHONE: 1-615-771-8786
FAX: 1-615-771-2801



We are conveniently located off I-65 at exit 68A. Travel Eastbound on Cool Springs Blvd. crossing Carothers Pkwy. Physicians Plaza of Cool Springs is a two story brick Building on the left. Turn left onto Billingsly Ct. and left again into our parking lot. Our office is located on the second floor; Suite 210.

Note: This facility is the last commercial Building on the left.

PATIENT INFORMATION

Name: ______________________________ Date: ____________________ Sex: □ Male □Female

Address: ______________________________ City,State & ZipCode: ____________________

Home Phone: ____________________ Cell: ____________________ Work: ____________________

Contact preference: □Home □Cell □Work Email: ______________________________

SSN #: ____________________ Date of Birth: ____________________

Race: ______________ or □ I decline to answer, Ethnicity: ______________ or □ I decline answer;

Employer Name: ______________________________ □Retired □FT Student □PT Student

Referring Physician: ____________________ Primary Care Physician ____________________

Emergency contact name: ____________________ Relationship to you: ____________________

Emergency contact phone number: ____________________

BILLING AND INSURANCE INFORMATION

Guarantor (person responsible for bills): ______________________________

Primary Insurance: ____________________ ID#: ____________________

Subscriber Name: ______________________________ Relationship to insured: Self Child Spouse

Subscriber Date of Birth: ____________________ Gender: _____ Male _____ Female

Secondary Insurance: ____________________ ID#: ____________________

Is policy holder spouse? _____ Yes _____ No Date of birth: ____________________

PLEASE INITIAL THE FOLLOWING:

________ **I hereby authorize** Wilmot C. Burch, MD & James R Davenport, MD and/or Franklin Surgery Center to furnish my insurance company any/all information which said insurance company(s) may request.

________ **I hereby assign** Wilmot C. Burch, MD & James R. Davenport, MD and/or Franklin Surgery Center all money to which I am entitled for Medical and or Surgical expenses relative to the service rendered.

________ **I understand that I am financially responsible to** Wilmot C. Burch, MD & James R. Davenport, MD and/or Franklin Endoscopy for charges **NOT** covered by this assignment, meaning services **NOT** covered by my insurance company.

________ **I understand that if I cannot pay my balance in full, I can set up a payment plan or apply for Care Credit.**

PATIENT SIGNATURE: ______________________________ Date: ____________________

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS CAREFULLY

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and healthcare options. Protected health information is the information that we create and obtain in providing our services to you. Such information may include documenting your symptoms; examination and test results, diagnoses, treatment and applying for future care treatment. This also includes billing documents for those services rendered by the physician(s) of Franklin Gastroenterology.

Example:

- A nurse or medical assistant obtains treatment information about you and records it in a health record (i.e. paper record and electronic record).
- During the course of your treatment, the physician determines whether he/she will need to consult with another specialist in the area.
- We submit requests for payment to your health insurance company, unless otherwise authorized by you to be a self-pay patient. In this case you will be charged for the services rendered by the physician.

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

May we the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, James R. Davenport, MD and/ or Franklin Surgery Center leave a message on your **home number, cell number or via the patient portal system;** regarding appointment reminders, normal test results or insurance payment information? _____ Yes _____No

May we the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, James R. Davenport MD and/or Franklin Surgery Center leave a message regarding any of the above with anyone other than you at your **home number**? _____Yes _____ No

Would you like for the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, James R. Davenport MD and/or Franklin Endoscopy Center to **file your insurance for the services rendered by the physician**?

_____Yes _____No

Please list the name(s) and relationship of the person(s) that we may discuss your medical condition.

Name	Relationship
______________________________	______________________________
______________________________	______________________________

A full copy of our office's Notice of Privacy Practices is available upon request.

Patient Signature: ______________________________ Date: ______________________

Patient Printed Name: ______________________________

Franklin Gastroenterology, PLLC & Affiliated Creditors Inc.
Financial Statement to Patients

Please be aware that we review past accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect the debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we will incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

Patient Signature: ______________________________ Date: ________________

Rx Eligibility History Disclaimer to Franklin Gastroenterology Patients:

Please be aware that we will retrieve a list of all medications submitted through your insurance company to upload into your electronic health record or EHR. Please sign and date below in acknowledgement.

______________________________ Date: ________________
Patient signature

Patient Preferred Pharmacy& Location:

____

Franklin Gastroenterology, PLLC

Patient Name: ______________________________ Date of Birth: ______________________________

Emergency Contact: __________________________ Phone Number: ____________________________

Health Information

Chief complaint: ____

Other Active Medical Problems:

1. ____________________________ 3. ____________________________

2. ____________________________ 4. ____________________________

Medication Allergies or Reactions ____
Explain: ____
Other Known Allergies: ____

Present Medications:

1. __________________ 3. __________________ 5. __________________

2. __________________ 4. __________________ 6. __________________

Frequently Used Non-Prescription Medications:
Aspirin: ______________ How Much: __________________ How Often: ______________
Laxatives: ______________ How Much: __________________ How Often: ______________
Other: ______________ How Much: __________________ How Often: ______________

Do you eat sugarless mints, candy or chew gum? ________________________________
Do you drink milk or eat dairy products? ______________________________________

Previous Hospitalizations/Surgery (Please List All):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Have you ever had a blood transfusion? ______Yes ______No; Most recent date : ______________

Franklin Gastroenterology, PLLC
Family History

Mother: Alive: Yes ______No ______; Age/Cause of Death: ________________________________
Father: Alive: Yes _______ No _______; Age/Cause of Death: ________________________________

Please list the number of Brothers, Sisters and Children in each Category Below:
Brothers: Alive: Yes ______No ______; Age/Cause of Death: ________________________________
Sisters: Alive: Yes _____No ________; Age/ Cause of Death: ________________________________
Children: Alive: Yes ______No ________; Age/Cause of Death: ______________________________

Do any diseases "Run In Your Family"? Please explain:
____

Social History

Do you smoke? Yes _____No _____; If so: how much/how often? ____________________________
Do you drink? Yes _______No _____; If so: how much/how often? ___________________________
Any history of HIV+ or AIDS? Yes _______ No _______
Any history of Tuberculosis (positive skin test of exposure)? Yes ______ No _______

Current Medical Condition

Please check appropriate response and briefly explain "yes" responses.

Constitutional Symptoms

Fever	Yes _____	No ____	______________________________
Weight Loss	Yes _____	No ____	______________________________
Weight Gain	Yes _____	No ____	______________________________
Night Sweats	Yes _____	No ____	______________________________

Eyes

Trouble with vision	Yes _____	No ____	______________________________
Dry Eyes	Yes _____	No ____	______________________________
Excessive Tearing	Yes _____	No ____	______________________________

Ear, Nose, Mouth and Throat

Trouble with hearing	Yes _____	No ____	______________________________
Tinnitus (ringing in ears)	Yes _____	No ____	______________________________
Epistaxis (nosebleeds)	Yes _____	No ____	______________________________
Trouble with smell	Yes _____	No ____	______________________________
Problems with bad breath	Yes _____	No ____	______________________________
Trouble with taste	Yes _____	No ____	______________________________
Mouth Ulcers	Yes_____	No ____	______________________________

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Ear, Nose and Throat (con't)

Symptom	Yes	No	Comments
Frequent Sore Throat	Yes ____	No ____	________
Hoarseness	Yes ____	No ____	________
Lump in Throat	Yes ____	No ____	________

Cardiovascular

Symptom	Yes	No	Comments
High blood pressure	Yes ____	No ____	________
Heart Murmur	Yes ____	No ____	________
Chest Pains.	Yes ____	No ____	________
Palpitations	Yes ____	No ____	________
Ankle Swelling	Yes ____	No ____	________

Respiratory

Symptom	Yes	No	Comments
Asthma or wheezing	Yes ____	No ____	________
Shortness of Breath	Yes ____	No ____	________
Chronic Cough (>3 weeks)	Yes ____	No ____	________
Blood sputum	Yes ____	No ____	________
Exposure to TB	Yes ____	No ____	________

Gastrointestinal

Symptom	Yes	No	Comments
Constipation	Yes ____	No ____	________
Diarrhea	Yes ____	No ____	________
Rectal bleeding	Yes ____	No ____	________
Black Tarry stools	Yes ____	No ____	________
Change in bowel habits	Yes ____	No ____	________
Abdominal pain	Yes ____	No ____	________
Nausea or Vomiting	Yes ____	No ____	________
Heartburn	Yes ____	No ____	________
Indigestion	Yes ____	No ____	________
Trouble Swallowing	Yes ____	No ____	________
Jaundice or liver trouble	Yes ____	No ____	________
Hemorrhoids or fissures	Yes ____	No ____	________
Hernia	Yes ____	No ____	________

Genitourinary

Symptom	Yes	No	Comments
Venereal disease	Yes ____	No ____	________
Frequent urination	Yes ____	No ____	________
Burning urination	Yes ____	No ____	________

Musculoskeletal

Symptom	Yes	No	Comments
Arthritis	Yes ____	No ____	________
Joint Swelling	Yes ____	No ____	________
Chronic Muscle Pain	Yes ____	No ____	________

Franklin Gastroenterology, PLLC

Integumentary (Skin and Breasts)

Itching problems Yes _____ No _____ ____________________

Rashes Yes _____ No _____ ____________________

Breast discharge Yes _____ No _____ ____________________

Painful breasts Yes _____ No _____ ____________________

Lumps in breasts Yes _____ No _____ ____________________

Neurological

Seizures Yes _____ No _____ ____________________

Black out spells Yes _____ No _____ ____________________

Temporary loss of vision Yes _____ No _____ ____________________

Chronic headaches Yes _____ No _____ ____________________

Psychiatric

Depression Yes _____ No _____ ____________________

Anxiety Yes _____ No _____ ____________________

Trouble Sleeping Yes _____ No _____ ____________________

Endocrine

Diabetes Yes _____ No _____ ____________________

Thyroid Problems Yes _____ No _____ ____________________

Hematological/Lymphatic

Anemia Yes _____ No _____ ____________________

Other blood problems Yes _____ No _____ ____________________

Other bleeding issues Yes _____ No _____ ____________________

Swollen glands Yes _____ No _____ ____________________

Allergies

Allergies Yes _____ No _____ ____________________

Sinus problems Yes _____ No _____ ____________________

Food allergies Yes _____ No _____ ____________________

Contact allergies Yes _____ No _____ ____________________

Women only

Irregular Menstrual Cycles Yes _____ No _____ ____________________

Painful Menstrual Cycles Yes _____ No _____ ____________________

Painful Intercourse Yes _____ No _____ ____________________

Age at Menopause Yes _____ No _____ ____________________

Birth Control Yes _____ No _____ ____________________

Could be pregnant Yes _____ No _____ ____________________

Any other concerns: ______________________________

Physicians Signature ______________________ Date ____________