HMG
HOLSTON MEDICAL GROUP

Welcome to our office

Where did you hear about us?
❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) _____

OFFICE USE ONLY
Physician: _____
Approved by: _____
Date: _____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name _____
First Middle Last

Address _____

City _____ State _____ Country _____ Zip _____ Phone # (____) _____

Birthdate _____ Sex M or F Race _____ Marital Status S M W D

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

May we contact you at work? Y N By E-Mail Y N E-Mail Address _____

Emergency Contact Name _____ Emerg. Phone # (____) _____

Relationship to billing party _____

Guarantor/Responsible Party

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Phone # _____

Birthdate _____ Sex M or F Marital Status S M W D

Social Security # _____ Driver's License # _____

Place of employment _____ Work Phone # _____

OTHER INFORMATION

Name and address of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone # _____

If you are currently under another physician's care, please list:

Name _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

INSURANCE

1. Primary Insurance Company Name _____

Group # _____ Policy Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

2. Secondary/Supplemental Insurance Name _____

Group # _____ Policy/Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date _____ Signature _____

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Holston Medical Group Otolaryngology
Medical History

Date: _____
MRN: _____

Referring Physician: _____

Name: _____**DOB**_____**Age**_____

Phone (home):_____**Work/ Cell**: _____

Primary reason for coming to see us? _____

_____

Medications: _____

_____

Allergies to medications: _____

Habits

Do you now use or have you ever used tobacco? Yes_____ No_____
If you use/used tobacco, which form? _____
If you quit, when? _____
Do you drink alcohol? Yes_____ No_____

Medical conditions/surgical history_____
_____

Family History

- Diabetes
- Migraine Headaches
- Cancer
- Hearing loss
- Tuberculosis
- Immune Disease

Other:

_____
_____
_____

Systems Review

General:
- Weight loss
- Fever
- Chills

Head and Neck:
- Headache
- Ringing in the ears
- Hearing loss
- Dizziness
- Nosebleeds
- Nasal Congestion
- Nasal Drainage
- Sore throat
- Difficulty swallowing
- Hoarseness

Eyes:
- Vision Changes
- Seeing Double
- Glasses

Endocrine:
- Temperature Intolerance
- Dry skin
- Weight gain

Cardiovascular:
- Chest pain
- Murmur
- Leg pain

Gastrointestinal:
- Nausea
- Heartburn
- Diarrhea
- Constipation

Urogenital:
- Blood in urine
- Incontinence
- Urinary stream is smaller

Neurologic:
- Fainting
- Unsteadiness
- Falls

Psychological:
- Insomnia
- Anxiety
- Depression

Musculoskeletal:
- Joint pain
- Joint swelling
- Limb pain

Skin:
- Skin discoloration
- Rash
- Sores

Hematologic:
- Easy bruising
- Anemia
- Easy bleeding

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MRN: _____

DATE RECEIVED: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on Holston Medical Group's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically, or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Patient Signature (if applicable) Date

_____ _____
Authorized Representative Signature Relationship to Patient

I understand that my protected health information will only be verbally communicated to those individuals listed below. Those individuals will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individuals that you want protected health information given to:

_____ _____

_____ _____

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:

_____

_____

_____

_____ _____
Employee Signature Date

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Parental Pre-Authorization for Minors

It is the policy of Holston Medical Group to comply with state and federal laws that govern the treatment of children under the age of 18. Under this law, it is necessary to have the presence of a parent or legal guardian or a signed document giving consent before evaluation and/or treatment can be rendered to children under the age of 18.

I (we) request and authorize Holston Medical Group and its personnel to provide medical care to my child:

Child's Name_____ Date of Birth_____

List any individuals other than the legal guardians to whom you give permission to bring your child in for medical treatment during your absence.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Note: If there is any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no-parent, etc.) Please explain in the space below with your signature, printed name and phone number at which you may be reached. A copy of the legal document will need to be obtained.

_____

_____

_____

_____

Legal Guardian/Parent's Signature_____

Printed Name_____ Phone_____

Witness_____ Date_____

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OTOLARYNGOLOGY - HEAD AND NECK SURGERY

Date_____

Name_____

MR#_____

DOB_____

Within the past month, how did the following problems affect you?	0 = No Problem 5 = Severe Problem					
Hoarseness or a problem with your voice	0	1	2	3	4	5
Clearing your throat	0	1	2	3	4	5
Excess throat mucus or post nasal drip	0	1	2	3	4	5
Difficultly swallowing food, liquids, or pills	0	1	2	3	4	5
Coughing after you ate or after lying down	0	1	2	3	4	5
Breathing difficulties or choking episodes	0	1	2	3	4	5
Troublesome or annoying cough	0	1	2	3	4	5
Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5
TOTAL						

HMG HOLSTON MEDICAL GROUP
Multi-Specialty Physician Practice
105 West Stone Drive • Suite 4-D • Kingsport, TN 37660 • Telephone (423) 392-6299 • Facsimile (423) 392-6920
Otolaryngology

Dizziness Questionnaire

Name_____ Date_____

Check the following that apply to the description of your dizziness.

- ❒ Lightheadedness
- ❒ Faint feeling
- ❒ Swimming sensation in head
- ❒ Room/objects spinning around you
- ❒ Feeling like your floating
- ❒ Unstable horizon
- ❒ Blackouts
- ❒ Imbalance

Occurs while

- ❒ Standing up
- ❒ Walking
- ❒ Turning
- ❒ Rolling over in bed

Check the following that associate with your dizziness.

- ❒ Nausea
- ❒ Vomiting
- ❒ Pressure in head
- ❒ Pressure in ear: (Left / Right / Both)
- ❒ Change in hearing: (Left / Right / Both) Describe_____
- ❒ Ringing in ear: (Left / Right / Both)
- ❒ Headaches
- ❒ Numbness : Where_____
- ❒ Weakness: Where_____
- ❒ Slurred speech

Describe your first experience of dizziness.

Date:_____

What were you doing when it started_____

How long did it last_____

Since the first event the dizziness

- ❒ Is constant
- ❒ Comes in attacks
  - ❒ Same as first

  How frequent_____

Do you have

- ❒ History of Migraine Headaches (self or family members)
- ❒ An autoimmune disease
- ❒ Skin Rashes
- ❒ Arthritis (extremities/back/neck)
- ❒ History of a whiplash injury
- ❒ Motion intolerance
- ❒ Trouble walking

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Otolaryngology

Name_____ Height_____ Weight_____

Snoring Questionnaire

Please indicate the likelihood that you would fall asleep in the following situations (Scale of 0-3). This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number of each situation.

0 = would never doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	**Chance of dozing**
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (i.e. theater or a meeting)	_____
As a passenger in a car for a hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____