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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NAME: _____
DATE: _____
EMR: _____

HMG Endocrinology – New Patient History Form

Please list the reason(s) you are here for evaluation:

_____
_____

PAST MEDICAL HISTORY:

Please circle if you have ever had any of the following conditions:

Diabetes	High blood pressure	High cholesterol
Coronary artery disease	Stroke	Peripheral vascular disease
Osteoporosis	Hypothyroidism	Hyperthyroidism
Cancer: Type _____		
COPD / Emphysema	Asthma	Kidney failure
Gastroesophageal reflux disease	Anxiety	Depression

Please list any other medical problems you have:

_____
_____

Please list any operations you have had, and the year performed:

_____
_____

FAMILY HISTORY:

Please list any important medical history involving your family members:

My father's medical problems include: _____
My mother's medical problems include: _____
I have _____ brothers. Medical problems include: _____
I have _____ sisters. Medical problems include: _____
I have _____ children. Medical problems include: _____

Please list any other important information regarding family member's medical history:

_____
_____

Do you smoke cigarettes?
If yes, how many packs a day? _____

Do you consume alcohol?
If yes, how many drinks a week? _____

Do you use any recreational or street drugs?
If yes, please explain: _____

WOULD YOU LIKE A REPORT SENT TO YOUR PRIMARY PHYSICIAN? _____

PRIMARY PHYSICIAN NAME: _____

REVIEW OF SYSTEMS: Are you CURRENTLY having any of the following:

Yes	No	**CONSTITUTIONAL**
		Fever
		Weight Loss
		Weight Gain
		Fatigue
		Excessive thirst
		Feeling excessively hot
		Feeling excessively cold
		Excessive sweating
		Lightheadedness

Yes	No	**EYES**
		Blurred vision
		Double vision
		Tunnel vision
		Bulging eyes
		Eye pain
		Eye dryness

Yes	No	**EAR/NOSE/THROAT/MOUTH**
		Dental problems
		Hoarseness/change invoice
		Neck swelling/goiter
		Difficulty swallowing/choking sensation
		Swollen lymph nodes/glands in neck

Yes	No	**CARDIOVASCULAR**
		Chest pain
		Heart racing
		Palpitations

Yes	No	**GASTROINTESTINAL**
		Abdominal pain
		Heartburn
		Nausea
		Vomiting
		Diarrhea
		Constipation

Yes	No	**MUSCULOSKELETAL**
		Muscle weakness
		Joint aches
		Muscle aches
		Loss of height
		Back pain

Yes	No	**INTEGUMENTARY**
		Rash
		Dry Skin
		Hair Loss
		Excessive hair growth
		Acne
		Easy bruising/bleeding

Yes	No	**NEUROLOGICAL/PSYCHOLOGICAL**
		Difficulty sleeping
		Depressed mood
		Excessive nervousness/anxiety
		Headaches
		Tremors
		Numbness/tingling

Yes	No	**ALLERGIC/IMMUNOLOGIC**
		Seasonal Allergies

Yes	No	**FOR WOMEN ONLY**
		Breast tenderness
		Fluid leakage from breast
		Irregular menstrual cycle
		Hot flashes
		Low sexual desire

Yes	No	**FOR MEN ONLY**
		Breast enlargement/tenderness
		Fluid leakage from breast
		Difficulty with erections
		Low sexual desire

OTHER: PLEASE LIST

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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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NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment **may be charged a fee** for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

Please Print Patient Name	Date of Birth	Account Number

Please Sign Authorized Representative	Relationship to Patient

Witness	Date