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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PEDIATRIC HISTORY FORM

Chart # _____

Doctor _____

Patient Name _____ ☐ Male ☐ Female Birth Date _____

Today's Date _____

Mother's Name _____ Age _____ Occupation _____

Father's Name _____ Age _____ Occupation _____

Mark appropriate box for parents:

Married ☐ Single ☐
Divorced ☐ Widowed ☐ Separated ☐

Child lives with: _____

Number of people in Household: _____

How many children has the mother had: _____

Which number is this one: _____

BIRTH HISTORY

During the mother's pregnancy with this child, did she:
(Circle yes or no)

1. Have high blood pressure? Yes No
2. Have sugar in your urine? Yes No
3. Have a Kidney or bladder infection? Yes No
4. Have German Measles (Rubella)? Yes No
5. Take medicines prescribed by her doctor or over the counter? Yes No
   If yes, what? _____
6. Consume Alcohol? If yes, amount _____ Yes No
7. Use any tobacco products? If yes, amount _____ Yes No
8. Have a dependency on drugs? Yes No
9. Was this child premature: Yes No
   If yes, number of weeks at birth _____
10. Did you have a difficult delivery? Yes No
11. Was the birth:
    Normal Vaginal _____ Breech _____ Cesarean _____
12. Child's weight at birth _____
13. Was there an RH problem? Yes No
14. Did the child have any of the following while in the nursery:
    - Breathing difficulty Yes No
    - Jaundice Yes No
    - Low blood sugar Yes No
    - Seizures Yes No

DIET HISTORY

Has this child been:

Breast fed _____ Bottle fed _____

Would you describe your child's eating habits as

- Excellent _____
- Good _____
- Fair _____
- Poor _____

Has your child taken Vitamins: Yes No

FAMILY HISTORY

Does the Mother or Father have any chronic illnesses? Yes No

If Yes, what? _____

Do any of your other children have any chronic illnesses? Yes No

If yes, what? _____

Have any of your child's family (include siblings, parents, grandparents, uncle or aunts) had any of the following illnesses or disorders:

(Mark an X in appropriate box)

Allergies		Diabetes	
Birth Defects		Hypertension	
Anemia		Heart Disease	
Arthritis		Kidney Disease	
Cancer		Mental Retardation	
Breast		Muscular Dystrophy	
Lung		Cerebral Palsy	
Colon		Psychiatric Problem	
Asthma		Rheumatic Fever	
Chronic Bronchitis		Tuberculosis	
Emphysema		Unexpected death of a child	
Ear / Eye Disease			

Does your child have any known allergies to medicines, food or pollen? Yes No

If yes, what _____

IMMUNIZATION DATES – or present copy of record

DPT _____

OPV/IVP _____

MMR _____

TB Skin test _____

List any medicines which your child takes:

Has your child been hospitalized for any operations or medical illnesses? Yes No

If yes, what? _____

Has your child had any of the following: (Please circle)

1. Measles
2. Mumps
3. Chicken Pox
4. Rheumatic Fever
5. German Measles
6. Croup
7. Frequent bronchitis or pneumonia
8. Frequent ear or throat infections
9. Asthma
10. Seizures

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PEDIATRIC MEDICAL HISTORY
(Age 2 & Above)

Today's Date _____/_____/_____ Chart # _____
Primary Provider _____
Patient's Name _____ ☐Male ☐Female Birth Date ____/____/_____
Mother's Name _____ Age _____ Occupation _____
Father's Name _____ Age _____ Occupation _____
Parents are ☐married ☐single ☐divorced ☐separated ☐widowed Number of people in household ____
Child Lives with: _____ Does he/she attend daycare ☐yes ☐no; Days per week ____
How many children has the mother had? _____ Which number is this Child? _____
Has this child had any serious health problems since the last update? _____
_____
Has this child had any immunizations by other providers since the last update? ☐yes ☐no _____
_____

Family History

Please check the appropriate area	Mother	Father	Sibling	mGM	mGF	pGM	pGF	other
Allergies – Food								
Allergies – Seasonal								
Allergies – Other								
Asthma								
Anemia								
Arthritis – Rheumatoid								
Arthritis – Other								
Cancer – Childhood								
Cancer – Leukemia								
Cancer – Other								
Emphysema – Nonsmoker								
Emphysema – Smoker								
Chronic Bronchitis								
Frequent Ear Infections								
Frequent Serious Infections								
Hearing difficulty/deafness								
Childhood eye disorder								
Childhood vision problem								
Diabetes – Insulin dependent								
Diabetes – non-insulin dependent								
High Blood Pressure								
High Cholesterol								
High Triglycerides								
Kidney disease								
Epilepsy – Convulsions								
Mental retardation								
Cerebral Palsy								
Tuberculosis								
Unexpected death of a child								
Birth defect/congenital disorder								
Other								

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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

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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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AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Holston Medical Group, PC is dedicated to maintaining the privacy of your protected health information (PHI), which is your individually identifiable health information (this includes such data as your name, address, phone number, date of birth, Social Security Number, account information, medical record number, or any other unique identifying number). In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:_____ **DOB:**_____ **SSN:**_____

I authorize Holston Medical Group to *release* copies of my records *to*:

_____
Name of Physician or Institution, etc.

_____
Address

_____
City, State, Zip

_____
Which dates of treatment do you need records for?

**Please check all that apply:

****Information to be Released:**
_____ Office Notes
(Encounter Notes, Telephone Notes, Memos)
_____ Radiology Reports
(X-rays, CT Scans, MRI, Ultrasound,etc.)
_____ Lab Results
_____ Immunization Record
_____ Consultations/Referrals
_____ Other _____

I authorize Holston Medical Group to *obtain* copies of my records *from*:

_____
Name of Physician or Institution, etc.

_____
Address

_____
City, State, Zip

_____
Which dates of treatment do you need records for?

Please send requested records to:

****Information will be used/disclosed for the following purpose(s):**
_____ Continuation of Care (for another provider)
_____ Personal Use
_____ Other_____

The patient or the patient's representative must read and initial the following statements:

_____ 1. I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about psychiatric services, and treatment for alcohol and drug abuse.

_____ 2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

_____ 3. I understand that I may revoke this authorization at any time by notifying *HMG* in writing. If I do revoke the authorization, it will not have any effect on any actions taken by *HMG* prior to their receipt of the revocation. Unless otherwise noted, I understand this authorization will expire ninety days from the date of my signature.

_____ _____
Signature of patient or patient's representative | Date

_____ _____
Printed name of patient or patient's representative | Relationship to patient

HMG.650

***For Internal Use Only:** Photo ID provided _____Yes _____No If No, attach a copy of the form used to validate the signature.