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

Emergency Phone # ( ) _____ Cell Phone # ( ) _____

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

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

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 _____

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 (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG'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. I also understand this may include sensitive information, including but not limited to: Urine Drug Screen results, laboratory test results, or information discussed during an office visit. Those individuals I list below, 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 individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:

_____

_____ _____
Employee Signature Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
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Revised: 10/12/2022

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 ❑ Separated ❑

Divorced ❑ Widowed ❑

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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MRN:_____

Date: _____

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:

Childs Name:_____ Date of Birth:_____

List any individuals other than the legal guardians to whom you give permission to bring your child in for any and all necessary medical treatment as recommended and deemed appropriate by your medical provider during your absence.

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. The legal documents will also need to be provided.

_____

_____

NOTICE: This authorization remains valid unless specifically revoked in writing by you.

Legal Guardian/Parent's Signature: _____

Printed Name:_____ Phone:_____

Witness:_____ Date:_____

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Attention: If you need language or translation services, please ask to speak with the Office Manager.

La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.

انتباه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، يرجى أن تطلب التحدث مع مدير مكتب

주의: 언어 또는 번역 서비스가 필요한 경우 사무실 관리자에게 문의하시기 바랍니

다.注意:如果您需要语言或翻译服务,请咨询门办公室经理交谈。

Revised 07.31.2019

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MRN:_____

Date Received:_____

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 who 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

_____ _____

Please Sign / Authorized Representative Relationship to Patient

_____ _____

Witness Date

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Patient: _____

MRN: _____

Communicating with Your Child's Pediatric Office

Access to Your Child's Physician and Staff

Your child's Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, Follow my Health. If you wish to communicate electronically, you may sign up at any office location. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your child's health care team through social media, such as **Facebook**, or **texting**. Your child's privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve your child is during regular clinic hours, but we understand acute illnesses can occur at any time. Your child's Primary Care Provider's telephone message will direct you on how to contact the HMG Physician on Call.

HMG Pediatric After-Hours Clinic and HMG Urgent Care

Please use the Emergency Room only in a true emergency (i.e. chest pain or shortness of breath). To avoid long wait times in the ER, HMG offers a Pediatric After-Hours Clinic for routine health concerns such as colds, ear aches, flu symptoms, sprains and strains, etc. It is located at our Medical Plaza Pediatric Office and staffed by HMG pediatric providers. Please refer to the HMG Website for hours of operation or call (423) 230-2430.

We also have two Urgent Care locations conveniently located in Bristol and Kingsport. For hours and specific information call (423) 230-2420 (Kingsport) or (423) 990-2466 (Bristol).

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your child's office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during regular business hours. Monthly refills of any controlled medications (pain medication, anxiety, etc.) will only be given during an office visit within regular business hours.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____