HOLSTON MEDICAL GROUP
Multi-Specialty Physician Practice

105 West Stone Drive, Suite 4-A • Kingsport, TN 37660 • Telephone (423) 392-6265 • Facsimile (423) 392-6272

General Surgery

Robert A. Rogers, M.D., F.A.C.S.
Steven M. Holt, M.D., F.A.C.S.
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Cheryl A. Stanski, M.D., F.A.C.S
Edward Fore, M.D., F.A.C.S.

We welcome you to Holston Medical Group General Surgery for your surgical needs. Our goal is to provide you with the most compassionate and high quality medical care. We value human life in that we treat everyone with dignity and respect, and are continually striving to improve all aspects of our performance.

To better serve you, upon arriving at our office, we have attached all forms and information that you will need to either complete or read. Please take this opportunity to do so in the privacy of your home and return to the receptionist upon your arrival. You will find in your packet a consent form regarding the Notice of Privacy Practices for Protected Health Information. This must be completed and returned to the receptionist stating that you have received a copy. A copy of the policy is available upon request.

Thank you for taking the time to bring along with you all medications and all Insurance Cards. If you have had a CT, MRI, Mammogram or x-ray at an HMG, Wellmont, or Mountain States facility, you will not need to obtain copies of the study. If it was performed at another facility, please obtain the films. Please note that if your insurance company requires that you have a written referral or verbal approval for your visit, please make sure that this is obtained prior to your appointment to reduce extended time or possibly rescheduling your visit. You may request that referrals be sent to our office via fax to (423) 392-6272. If you are being seen for worker's compensation, please bring along the appropriate information with you to your visit, along with an approval number obtained by your employer.

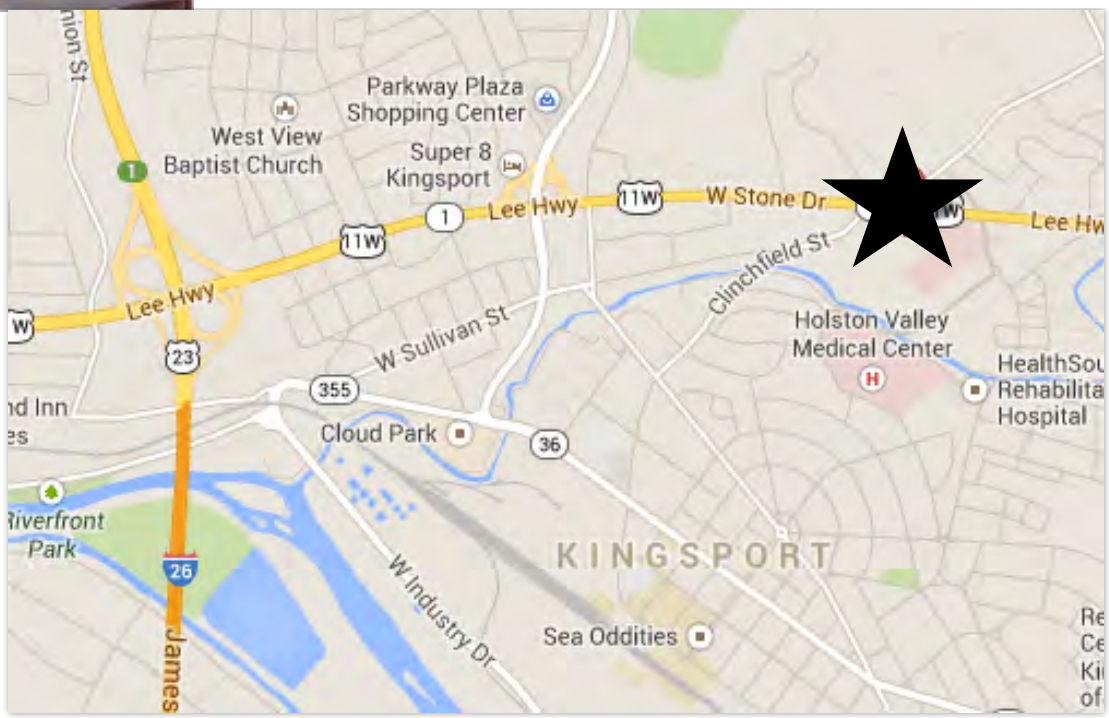
Please note that due to the aspects of our specialty we do receive emergencies and the doctor may be detained in surgery or may have to leave for an emergency. We do apologize if this should happen, as we value human life in every stage from conception to death, treating everyone with dignity and respect. If you should have any complaints or compliments, please feel free to give me a call at (423) 392-6265 or you may contact Amanda Cross, Compliance Officer at (423) 857-2792.

For directions, please see map listed on the back of this letter!

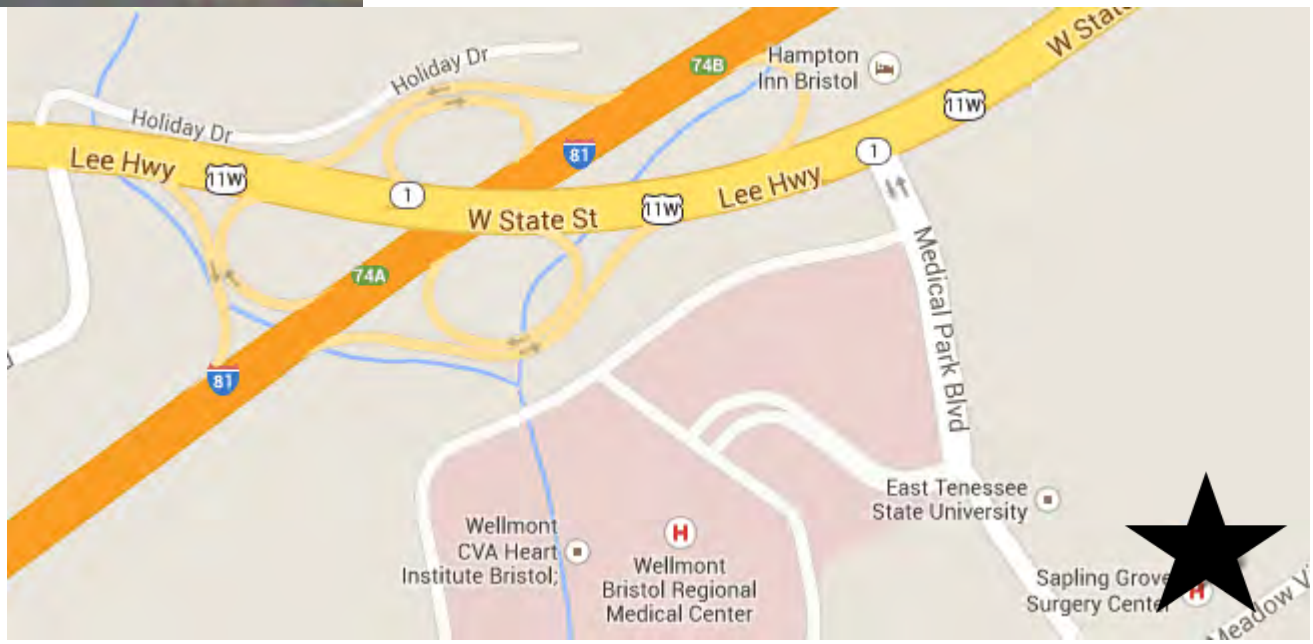
Sincerely,

Tory B. Lorimer
Practice Manager
HMG General Surgery

HMG Medical Plaza
105 West Stone Drive, Kingsport, TN



Sapling Grove Professional Building
240 Medical Park Blvd, Bristol, TN



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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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MRN #_____

Date_____

Name_____ Age_____

Which Doctor requested us?_____ Date of Birth_____

Reason for visit today_____

MEDICAL HISTORY: Please circle Yes or No if you have ever had any of the following:

Yes	No	Sleep Apnea	Yes	No	Kidney Stone	Yes	No	Hodgkin's Disease
Yes	No	High Blood Pressure	Yes	No	Kidney Infection	Yes	No	Pelvic Infections
Yes	No	Heart Failure	Yes	No	Prostate Trouble	Yes	No	Hernia
Yes	No	Heart Attack	Yes	No	Emphysema	Yes	No	Ulcer Disease
Yes	No	Heart Murmur	Yes	No	Asthma	Yes	No	Aneurysm
Yes	No	Angina	Yes	No	Bronchitis	Yes	No	Cirrhosis
Yes	No	Stroke	Yes	No	Pneumonia	Yes	No	Ulcerative Colitis
Yes	No	Transient Ischemic Attack	Yes	No	Anesthetic Problem	Yes	No	Crohn's Disease
Yes	No	Seizure	Yes	No	Collapsed Lung	Yes	No	Bowel Obstruction
Yes	No	Vascular Disease	Yes	No	Diabetes	Yes	No	Rectal Problems
Yes	No	Disc Disease	Yes	No	Thyroid Problems	Yes	No	Blood Clots
Yes	No	Eye Disease	Yes	No	Phlebitis	Yes	No	Depression
Yes	No	Hepatitis	Yes	No	Breast Problems	Yes	No	Pancreatitis
Yes	No	Bleeding Disorder	Yes	No	Cancer of any kind	Yes	No	Lupus

Last Colon Screening_____

Previous Surgeries_____

_____

_____

Medications_____

_____

Allergies_____

SOCIAL HISTORY: Have you ever been a smoker? Start Age _____ Stop Age_____

Alcohol: ❒ Yes ❒ No Illegal Drugs: ❒ Yes ❒ No

History of family health problems: (Please List)

Father_____ Brothers_____

Mother_____ Sisters_____

Grandparents_____

Female Only:

Last Mammogram_____

Are you pregnant or any possibility of being pregnant? ❒ Yes ❒ No Age of first pregnancy?_____

Number of pregnancies:_____ Number of children:_____ Number of miscarriages_____

Year of first period_____ Last period_____ Last Pap Smear_____

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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