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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**Orthopaedic Department**

Today's Date _____

Name _____ Age _____ Date of Birth _____

Social Security Number _____ Family Dr. or Pediatrician _____

Why are you here today? _____ Family Dr. Or Pediatrician Address _____

When did problem begin? _____ Family Dr. Or Pediatrician Phone # _____

Occupation _____ Hobbies _____

What hand do you eat/write with? (Circle One) R L Both School Name _____ Grade _____

**MEDICAL HISTORY:** Have you had any of these problems ?

| PROBLEMS | YES | NO | COMMENTS: |
|---|---|---|---|
| High Blood Pressure | | | |
| Diabetes (Sugar) | | | Pill or Insulin? |
| Chest Pain (Angina) | | | |
| Shortness of Breath | | | |
| Stroke | | | |
| Chronic Bronchitis | | | |
| Emphysema | | | |
| Asthma | | | |
| Hepatitis | | | What Type? |
| Stomach Ulcer | | | |
| Frequent Urinary Infections | | | |
| Cancer or Tumor | | | |
| Bone Infection (Osteomyelitis) | | | |
| Arthritis | | | Where |
| Thyroid Problems | | | High or Low |
| Gout | | | |
| Anemia (Low Blood Count) | | | |
| High Cholesterol | | | |
| Depression | | | |
| Blood Clots | | | |
| Sickle Cell Disease | | | |
| Rheumatic Fever | | | |
| Kidney Problems | | | |
| Sleep Apnea | | | |
| Other Problems? | | | |
| | | | |

**PREVIOUS SURGERY:** Have you had surgeries in the past? ❒ Yes ❒ No Describe:_____

_____

_____

**ALLERGIES:** Are you allergic to: (Circle all that apply) None Penicillin Aspirin Shellfish Iodine Other (Please List)_____

What happens when you take this? Rash Hives Itching Swelling Nausea/Vomiting Other (Please List)_____

MEDICATIONS: What medications do you take?

| Medication | Dose (milligrams) | Number of times per day | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**SOCIAL HISTORY:** Do you drink alcohol? ❒ Yes ❒ No Number of drinks per week_____

Do you smoke? ❒ Yes ❒ No Number of packs per day_____

Have you ever used any illegal drugs? ❒ Yes ❒ No Type_____ How taken into the body: Smoke Inject Inhale By Mouth

Who lives at home with you? Mother Father Husband Wife Boyfriend Girlfriend Other_____

Children ( How many? Ages?) _____

_____

**REVIEW OF SYSTEMS**: Do you frequently have any of the following symptoms (Circle all that apply)

Const: FEVER CHILLS NIGHT SWEATS
UNEXPLAINED WEIGHT LOSS > 10 POUNDS

Eyes: BLURRED VISION DOUBLE VISION EYE PAIN

Card: CHEST PAIN IRREGULAR HEART BEAT

Resp: SHORTNESS OF BREATH FREQUENT COUGH COUGHING BLOOD

GI: FREQUENT STOMACH PAIN VOMITING BLOOD BLOOD IN STOOLS
DARK BLACK STOOLS

GU: PAIN/BURNING WITH URINATION TROUBLE STARTING URINATION

Musc: PAIN IN JOINTS PAIN IN MUSCLES MORNING STIFFNESS
SWOLLEN JOINTS

Skin: OPEN SORES ENLARGING MOLES

Neuro: DIZZINESS HEADACHES POOR COORDINATION NUMBNESS

Psych: DEPRESSION ANXIETY HEAR VOICES

*Is there any other information you would like to provide about your medical, surgical , or social history that may assist me in caring for you?*

_____

_____

_____

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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

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**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:**

_____ _____

_____ _____

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***FOR INTERNAL USE ONLY:***

Reason Acknowledgement Could Not Be Obtained:

_____

_____

_____

_____ _____
Employee Signature Date

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# NO SHOW POLICY II

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.

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 |
|---|---|

# ADVANCE DIRECTIVES

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use; when not to treat, and/or when to stop treatment. Your family may not know what you would desire or may not agree on what would be best for you. It is best if they are aware of what you would desire and who you want to make those decisions on your behalf.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to plan and direct the types of health care you may receive if you become unable to express your wishes. You can exercise this right by making an Advance Directive.

Different providers have, in accordance with state law, varying practices regarding the implementation of an Advance Directive. Information regarding such practices must be made available to you, upon request, when selecting or receiving care from the provider.

If your physician, as a matter of conscience, is unable to comply with your directives, he/she must take all reasonable steps to arrange to transfer you to another physician.

**WHAT IS AN ADVANCE DIRECTIVE?**
An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of “sound mind”, you can make an advance directive.

There are two types of formal advance directives. You can complete a Living Will, a Power of Attorney for Health Care, or both.

**I have read and understand the above:**

Name: _____

Signature: _____ Date: _____

Date of Birth: _____ MRN: _____

**LIVING WILL**
A Living Will informs your physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your physician that, when you are near death or in a vegetable state, he or she should not use life prolonging, measures which postpone, but do not prevent, death.

**POWER OR ATTORNEY FOR HEALTH CARE**
The Power or Attorney for health care is a form that you can complete to appoint another person (a “health care agent”) to make health care decisions for you if you are not capable of making them yourself.

**MAINTAINING YOUR ADVANCE DIRECTIVE**
You should review and update your advance directive periodically. You have the right to change or discontinue your directive at any time. You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safe deposit box) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located. Be sure your physician has a copy of your advance directive in your medical file.

Most states have specific rules as to what will be recognized as a valid advance directive. Below is an address for further information.

**DO ALL STATES RECOGNIZE MY DIRECTIVES?**
If you plan to spend time in a state other than your state of residence, from which you obtained your Advance Medical Directive, you may wish to execute advance directives in compliance with that state’s laws as well.

Specific questions should be directed to your physician and or attorney for guidance.

Follow the instructions provided by your state when completing the Advance Directive forms.

To obtain additional information, brochures, or forms you may write to the address below:

**Tennessee Commission on Aging**
Nashville, TN 37243-0860

**Virginia Department for the Aging**
1610 Forest Avenue, Suite 100, Richmond, VA 23229