



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



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	<u>CONSTITUTIONAL</u>
		Fever
		Weight Loss
		Weight Gain
		Fatigue
		Excessive thirst
		Feeling excessively hot
		Feeling excessively cold
		Excessive sweating
		Lightheadedness

Yes	No	<u>EYES</u>
		Blurred vision
		Double vision
		Tunnel vision
		Bulging eyes
		Eye pain
		Eye dryness

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

Yes	No	<u>CARDIOVASCULAR</u>
		Chest pain
		Heart racing
		Palpitations

Yes	No	<u>GASTROINTESTINAL</u>
		Abdominal pain
		Heartburn
		Nausea
		Vomiting
		Diarrhea
		Constipation

Yes	No	<u>MUSCULOSKELETAL</u>
		Muscle weakness
		Joint aches
		Muscle aches
		Loss of height
		Back pain

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

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

Yes	No	<u>ALLERGIC/IMMUNOLOGIC</u>
		Seasonal Allergies

Yes	No	<u>FOR WOMEN ONLY</u>
		Breast tenderness
		Fluid leakage from breast
		Irregular menstrual cycle
		Hot flashes
		Low sexual desire

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

OTHER: PLEASE LIST



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 (PHI) will only be verbally communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed 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.

Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina



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