Patient Acct#_____

Blue Ridge Family Medicine

Patient Registration Form

Name _____
Last *First* *Middle*

Mailing address_____

City_____ State_____ Zip code_____ Home phone_____

Cell phone_____ Sex: M or F

E-mail address_____Birthdate_____/_____/_____

Marital Status_____ Race_____ Hispanic/Non-Hispanic

Language_____ Social Security_____ Employer_____

Person Responsible for Payment (if different from person listed above)

Name_____
Last *First* *Middle*

Relationship to patient_____ Home Phone_____ Cell Phone_____

Social Security #_____Mailing address_____

City_____ State_____ Zip Code_____ Employer_____

Insurance Information

Name of Primary Insurance_____ Subscriber ID#_____

Policy Holder_____ Birth date____/____/____ Group #_____

Name of Secondary Insurance_____ Subscriber ID#_____

Policy Holder_____ Birth date____/____/____ Group #_____

Emergency Contact Information

Name_____Phone_____

Relationship to patient_____

_____ _____

Patient (or guardian) Signature *Date*

_____

State of Franklin Healthcare Associates, PLLC
Registration, Billing and Collection

Payment Policy

Payment is due at the time of service. Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we will provide you with a completed third party payer claim form to use in filing your insurance.

We are participating providers with the Medicare Program. We will file your charges with Medicare and your Medicare supplemental insurance policy. If you do not have a Medicare supplemental insurance policy, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

Contracted Medicaid, HMO and PPO patients are expected to pay any deductibles, coinsurance or copay amounts owed at time of service. We will file these claims with the insurance carriers.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

2. Our fees fall within the acceptable range of most insurance companies and are covered up to the maximum allowance determined by each insurance carrier. Any portion not covered is the responsibility of the patient.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Any service not covered is the responsibility of the patient.

Regardless of insurance payment, the patient remains responsible for all financial obligations incurred at the time of service, and the balance must be paid in full 90 days from the date of service.

We realize temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance at 794-1800.

Signature: _____ Date: _____

Witness: _____ Date: _____

Blue Ridge Family Medicine

Privacy Acknowledgement

May we call the telephone number you have provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results?

_____ YES ____ NO

*If NO, what other number at which we may try to reach you to leave a message?

_____

May we mail to your home address information regarding your appointment or test results?

_____ YES ____ NO

May we email your health information to the email address you have provided?

_____ YES ____ NO

If yes, please list email address:_____

Do you wish us to share your health information with a family member, friend, or other person or entity? If so, please list these below:

Name	Relationship/Phone
_____	_____
_____	_____
_____	_____

Authorization

I have been given the opportunity to review the Notice of Privacy Practices and understand that the notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the notice of Privacy Practices for further review.

I authorize the release of any medical information, including information related to Psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical activities. I hereby request any benefits on my behalf be paid to the physicians. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Patient (or guardian) Signature Date

_____ _____

Patient Name (please print) Date

Voluntary Questionnaire

Our electronic medical records system maintains certain demographic information used for a variety of purposes, including reference ranges for patient care and government reporting of statistical information. We ask all new patients to voluntary self-identify the information below and are asking our current patients to confirm it so we may verify our records. Completion of this form is voluntary and is not required. The use of information you provide will be consistent with patient care and privacy practices.

Ethnicity Categories	Select One
Hispanic or Latino	
Non-Hispanic or Latino	
Race Categories	**Select One**
Black, African American	
Asian	
White	
American Indian, Alaska Native	
Native Hawaiian, Other Pacific Islander	
Two or More Races – please specify:	
Decline - Do Not Wish to Participate	

ETHNICITY

- Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Not Hispanic or Latino – A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

RACE

- Black or African American – A person having origins in any of the black racial groups of Africa, including those who consider themselves to be "Haitian."
- Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- White – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- American Indian or Alaska Native (not Hispanic or Latino) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- Two or More Races – A person having origins in more than one of the above races.

Patient Signature or Guardian/Representative _____ Date _____

Today's Date _____

Blue Ridge Family Medicine
Personal Health History

Name_____ Sex: M F Age_____ D.O.B. _____

Advance Directives
Do you have a Living Will? Yes ____ No____ If not, please notify us and we will provide this to you.
Do you have a Durable Power of Attorney for Health Care? Yes ___ No ____
*If so, please bring a copy with you

Allergies
Please list any medication or contactant allergies (latex, adhesive tape, etc.)_____
_____

Hospitalizations and Surgeries

	Procedure	Date	Facility
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			
8.)			
9.)			
10.)			

Immunizations
Pneumonia _____/_____/_____ Flu _____/_____/_____ Tetanus _____/_____/_____

Women's Health
Number of Pregnancies _____ Children Born _____ Last Menstrual Period _____/_____/_____
Age of Menopause _____ Date of last PAP, Pelvic Exam _____/_____/_____
Date of last Mammogram _____/_____/_____ Do you do regular self-breast exams? Y N

Social History
Occupation _____Employer _____
Marital Status: Married ____Divorced ____Widowed_____ Spouse's Name _____
Church/Religious Affiliation _____
Tobacco Use: Smoker ____ Non-Smoker ____Packs per day _____ Smoked for how many years? _____
Smokeless Tobacco (snuff, chewing tobacco) ____ How many years? _____
Alcohol Use: How many drinks per day____ week_____? Drinking for how many years? _____
Do you wear seat belts? Yes_____ No_____

How many days per week do you exercise? None ____3-4 times per week ____Daily ____every other day

Family History

List all major illnesses, or cause of death experienced by your family members (blood relatives)

	DOB	Living	Deceased at age	Major illnesses or causes of death
Mother				
Father				
Sister (s)				
Brother (s)				
Daughter (s)				
Son (s)				

Medical History

Please check if you have had any of the following:

___ Diabetes	___ Asthma	___ Ear Disease	___ Bladder Infections
___ Thyroid Diseases	___ Bronchitis	___ Sinus Problems	___ Prostate Problems
___ High blood pressure	___ Seasonal Allergies	___ Ulcers	___ Urinary problems
___ Heart attack	___ Colitis, bowel disease	___ Skin problems	___ Venereal disease
___ Angina (chest pain)	___ Liver disease, hepatitis	___ chronic headaches	___ Alcoholism
___ Heart rhythm problem	___ Gallbladder disease	___ Seizures	___ Depression
___ Heart Murmur	___ Anemia	___ Stroke	___ Drug Abuse
___ Rheumatic fever	___ Easy bleeding	___ Paralysis	___ Nervous Breakdown
___ High Cholesterol	___ Blood clots	___ Arthritis	___ Suicide Attempt
___ Lung disease	___ Cancer or tumor	___ Lupus	___ Psychiatric disorder
___ Emphysema	___ Eye disease	___ Bone fractures	___ other
___ Pneumonia	___ Glaucoma	___ Muscular problems	_____
___ Tuberculosis (TB)	___ Cataracts	___ Kidney stones	_____

List of Other Providers who treat you

	Name	Specialty	Phone/Fax
1.)			
2.)			
3.)			
4.)			
5.)			

Medications

	Name	Dosage (mg)	Frequency
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			
8.)			
9.)			
10.)			
11.)			
12.)			
13.)			
14.)			
15.)			
16.)			
17.)			
18.)			
19.)			

Patient ID _____

State of Franklin
HEALTHCARE ASSOCIATES
Your Health, Our Focus

Blue Ridge Family Medicine
Ronald L. Blackmore, M.D.
Gretchen H. Bowling, M.D.
Jason A. French, M.D.
Guy W. Robins, M.D.
Brian K. Way, D.O.
James Aderhold, PA-C
Megan Long, FNP-C
April Painter, FNP-C

PHYSICAL EXAM QUESTIONNAIRE

NAME: _____ DATE: _____

Please check all that apply:

General:
- ☐ Feeling Well
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Fever

Skin
- ☐ Bruising
- ☐ Change in wart/mole
- ☐ Excessive sweating
- ☐ Hair loss
- ☐ New lesions
- ☐ Rash

Hearing, eyes, ears, nose & throat
- ☐ Double vision
- ☐ Visual loss
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in the ears
- ☐ Nose bleed
- ☐ Seasonal Allergies
- ☐ Runny nose
- ☐ Sinus pain

Neck
- ☐ Neck pain
- ☐ Swollen glands

Respiratory
- ☐ Cough
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Shortness of breath

Breast (Females only)
- ☐ Breast mass
- ☐ Breast pain
- ☐ Breast tenderness
- ☐ Nipple discharge

Cardiovascular
- ☐ Chest pain
- ☐ Fainting
- ☐ Blacking out
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Abnormal blood pressure
- ☐ Difficulty breathing laying down
- ☐ Swelling of extremities/edema

Gastrointestinal
- ☐ Abdominal mass
- ☐ Abdominal pain
- ☐ Black, tarry stool
- ☐ Bloody stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Female Genitourinary
- ☐ Blood in urine
- ☐ Change in bladder habits
- ☐ Incontinence
- ☐ Menstrual irregularities
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Pelvic pain
- ☐ Urgency
- ☐ Urinating at night
- ☐ Vaginal Discharge

Male Genitourinary
- ☐ Blood in urine
- ☐ Change in bladder habits
- ☐ Impotence
- ☐ Testicular mass
- ☐ Urinating at night
- ☐ Need for erection meds

Musculoskelatal
- ☐ Leg cramps
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

Neurological
- ☐ Decreased memory
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Tremor
- ☐ Dizziness

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Panic Attacks
- ☐ Suicidal thoughts

Endocrine
- ☐ Appetite Changes
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Thyroid problems
- ☐ Heat intolerance

Hematology
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Blood clots
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

State of Franklin Healthcare Associates—Authorization for Disclosure of Health Information

1. I hereby authorize _____(Physician's Name & Telephone #) to disclose the following information from the health records of:

Patient Name:_____ Date of Birth:_____
Address:_____ Telephone: _____
_____ Social Security:_____

Medical Record #:_____

Covering the period(s) of health care:
From (date): _____ To (date):_____

From (date): _____ To (date):_____

2. Information to be disclosed:

____ Complete health record(s)
____ History & physical examination
____ Consultation reports
____ X-ray reports
____ Other (please specify)
_____

___ Discharge summary
___ Progress notes
___ Laboratory tests
___ Photographs, video, digital or other images

I understand that this will include information relating to (check if applicable):
_____ acquired immunodeficiency syndrome (AIDS)
_____ human immunodeficiency virus (HIV) infection
_____ behavioral health service/psychiatric care
_____ treatment for alcohol and/or drug abuse

If applicable, the following information should not be disclosed:_____
_____

3. This information will be disclosed to: _____
_____

for the purpose of _____

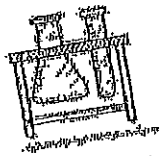
4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. To revoke the Authorization, I understand I must contact the following in writing: State of Franklin Healthcare Associates, attn: Privacy Officer, 2528 Wesley St., Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire on the following date, event, condition or within one year from the time I signed this form:
5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware that information will be released to a non-custodial parent unless we have a court order stating otherwise.

Signed:_____(Patient) Date:_____
_____or (legal rep.)
_____(Relationship to patient)
Signature of Witness:_____ Date:_____

Account # _____

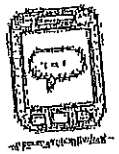
Access Your Medical Information Online!

24/7 anywhere, anytime access



View test and lab results

Schedule appointments

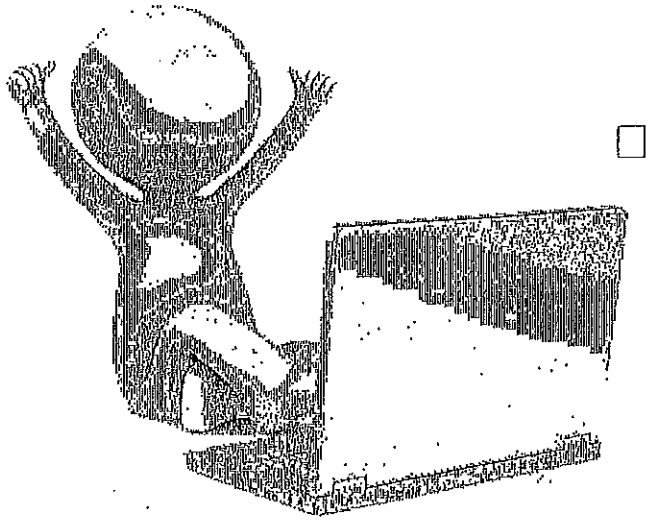


Receive email care reminders

Set up proxy accounts for children and dependent adults

Send and receive secure online messages

Request Rx refills



After signing up below, expect to receive additional information on how to register via email.

☐ Yes, I would like to enjoy the benefits of accessing my personal health information through Follow my Health.

Patient's Name (please print): _____

Patient's DOB: _____

Guarantor's Name: _____

E-mail Address: _____

State of Franklin Healthcare Associates