

Personal History
FirstChoice Internal Medicine

Name: _____ Sex: _____ Age: _____ Date of birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____ Email: _____

List names of additional physicians you see: _____

Date of last Exam: _____

Social History

Occupation: _____ Employer: _____

Marital Status: _____ Living Situation: _____

Education Level: _____ Sex Partner: Male _____ Female _____

Hobbies/Interests: _____

Habits: (Check those that apply to you)

Smoke Cigarettes or Cigars: how many packs per day? _____ How many years? _____

Smokeless Tobacco (chewing, snuff) How many years? _____

Alcohol: How many drinks per day? _____ Per week? _____

Using or taking illegal drugs?

Wear Seatbelts?

Exercise regularly? If yes: How many times per week? _____

Advanced Directives:

Do you have a living will or medical durable power of attorney? Yes ____ No ____ (if yes please bring a copy with you)

Allergies and Reactions: (please describe reactions)

Medication Allergies _____

Food or Environmental Allergies: _____

Immunizations: (Please bring a copy of your immunization records)

Last Tetanus Shot? _____ (Year) Last Flu Shot? _____ (Year) Last Pneumococcal (pneumonia) shot? _____ (Year)

TB Skin Test? _____ (Year) Positive? _____ Negative? _____

Other Immunizations? (Please list injection and year) _____

Woman’s Health

Number of pregnancies _____ Number of children born _____ Method of birth control _____

Date of last Pap smear, pelvic exam? _____ Any abnormal pap smears? _____ if yes please list date _____

Have you had a hysterectomy? _____ Vaginal hysterectomy? (Date) _____ Abdominal hysterectomy? (Date) _____

Was it a total hysterectomy? _____ partial hysterectomy? (also called Supracervical) _____ radical hysterectomy _____

Last menstrual period? (Date) _____ Age of menopause? _____ Hormone therapy? _____

Date of last mammogram? _____

Health Maintenance

Have you had a colonoscopy? Yes _____ No _____ (if yes please list date and physician) _____

Have you had a bone density test? Yes _____ No _____ (if yes please list date/year) _____

When was your last eye exam? (Date) _____ Physician/Clinic _____

Past Surgical History (please list all past surgeries)

Surgery	Date	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History (please check all that apply)

- Acne
- Allergies (seasonal)
- Alzheimer's disease
- Anemia, type _____
- Anxiety
- Arthritis, type _____
- Asthma
- Arrhythmia
- ADD
- B12 Deficiency
- Bipolar Disease
- Bone Fracture, site _____
- Blood Clot, site _____
- BPH (enlarged prostate)
- Bronchitis (chronic)
- Heart Disease (coronary artery)
- Cancer, type _____
- Carpal Tunnel Syndrome
- Cataracts
- Chicken Pox, year _____
- Colitis
- Colon Polyp (benign)
- Congestive heart failure (CHF)
- Constipation
- COPD (emphysema)
- Chron's disease
- Depression
- Diabetes Type I, controlled? Y N
- Diabetes Type II, controlled? Y N
- Diabetes, Gestational (diabetes during pregnancy)
- Ear Infections (chronic)
- Eczema
- Epilepsy (seizure disorder)
- Erectile dysfunction
- Fatigue
- Fibromyalgia
- Gallbladder disease
- GERD (heartburn)
- Glucose intolerance
- Gout
- Headaches (chronic), type _____
- Hearing loss
- Heart attack, year _____
- Heart Disease
- Heart Murmur
- Heart Palpitations
- Heart Valvular Disease
- Hemorrhoids
- Hepatitis, type _____
- High blood pressure
- High cholesterol

- Hyperthyroidism
- Hypothyroidism
- Irritable bowel syndrome (IBS)
- Kidney Infection
- Kidney Stones
- Low back pain (chronic)
- Liver disease, type _____
- Lupus
- Menstrual problems, type _____
- Mental Retardation
- MSRA (skin infection)
- Neck pain (chronic)
- Obesity
- Osteopenia
- Ovarian Cysts
- Panic attacks
- Pneumonia
- Polycystic Ovaries
- Prostate infection
- Restless leg syndrome
- Rosacea
- Scoliosis
- Sexually transmitted disease type _____
- Shingles
- Sinusitis (chronic)
- Sleep apnea
- Sleep problems
- Stroke
- Suicide attempt
- Thyroid Nodule
- TMJ
- Ulcers
- UTI (urinary tract infections (chronic))
- Urinary incontinence
- Vertigo

Other conditions not listed: _____

Voluntary Questionnaire
(You are not required to answer questions)

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 voluntarily 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 completely voluntary and is not required. The use of information you provided will be consistent with patient care and privacy practices.

Ethnicity Categories	Select One (√)
Hispanic or Latino – person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race	
Non-Hispanic or Latino – person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race	
Race Categories	Select One (√)
Black, African American – person having origins in any of the black racial groups of Africa, including those who consider themselves to be Haitian	
Asian – 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 – person having origins in any of the original peoples of Europe, North Africa, or the Middle East	
American Indian, Alaska Native (not Hispanic or Latino) – 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, other Pacific Islander (not Hispanic or Latino) – person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands	
Two or more races, please specify: person having origins in more than one of the above races	
Decline – Do not wish to participate	

Patient Signature or Guardian/Representative

Date



Your Health, Our Focus

**State of Franklin Healthcare Associates, PLLC
Registration, Billing and Collection
Payment Policy**

We are participating with Medicare, Tennessee Medicaid, and most Managed Care plans in the area. We will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service. If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage plan, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

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.

Patients with a High Deductible Health Plan that have not met their annual deductible amount on the date of service will be asked to pay SoFHA's estimate of the allowed charges at the time of service. You will be billed for any additional deductible amounts after the insurance processes the claim.

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.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you will be liable for.
2. Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient/guarantor.
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/guarantor.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service and we will be happy to assist you in making payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted.

Patient Name

Patient Date of Birth

Patient or Guardian Signature

Date