



### Demographic Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
SSN: \_\_\_\_\_ Gender:  Male  Female Ethnicity:  Hispanic or Latino  Non-Hispanic or Latino  
Race:  Black / African American  Asian  White  American Indian  Native Hawaiian/ other Pacific Islander  
 Unknown  Decline  
Marital Status:  Married  Single  Divorced  Widowed  
Home Address: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Emergency Contact (Name) \_\_\_\_\_ (Relationship) \_\_\_\_\_ (Phone) \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's SSN: \_\_\_\_\_ DOB \_\_\_\_\_

### Care Team Information

Primary Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Usual Pharmacy: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
DME Supplier: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

### Authorization

I authorize Medical Specialists of Johnson City to release 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 information that is needed for utilization review or quality assurance activities. I authorize and request the above names insurance companies to pay directly to Medical Specialists of Johnson City and benefits due for their medical or surgical services rendered to me. I understand that I am responsible for payment of any and all charges incurred by me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
(Signature of patient or responsible party)

\_\_\_\_\_  
(Date)



# Review of Systems

## GENERAL

- Recent weight loss
- Recent weight gain
- Wake feeling unrested
- Fatigue during the day
- Weakness
- Fever / chills

## SKIN, HAIR & NAILS

- Nodules / lumps
- Easy bruising
- Change in fingernails
- Hand color change upon exposure to cold
- Hair loss
- Hives
- Puffy Hands
- Rash
- Expanding red, circular rash
- Sensitivity to sun

## HEENT

### EYES

- Blurred vision
- Double vision
- Dry eyes
- Eye Pain
- Eye redness
- Gritty sensation in eyes
- Visual loss

### EARS, NOSE & THROAT

- Hearing loss
- Ear pressure sensation
- Sores in mouth
- Dry nose
- Nose bleed
- Frequent sinus problems
- Bleeding gums
- Hoarseness
- Oral ulcers
- Dry mouth
- Sore throat
- Sore tongue

## RESPIRATORY

- Cough
- Difficulty breathing at night
- Pleurisy / pleuritic history
- Shortness of breath
- Bloody Sputum

## CARDIOVASCULAR

- Angina
- Chest Pain
- Leg pain and/or swelling
- Heart murmur
- Irregular heart beat
- Pressure sensation in chest
- Shortness of breath on exertion

## GASTROINTESTINAL

- Abdominal pain
- Black tarry stool
- Bloody stool
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting
- Vomiting of blood

## GENTOURINARY

- Blood in urine
- Difficulty urinating
- Discharge from penis/ vagina
- Frequent urination
- Kidney stones
- Painful urination
- Pus in urine
- Excessive urination at night

## FEMALE

- Bleeding after menopause
- Irregular periods
- Date of last menstrual period \_\_\_\_\_

## MUSCULOSKELETAL

- Joint pain
  - Joint swelling
- List joints affected: \_\_\_\_\_

- Muscle pain
- Muscle stiffness
- What time of day? \_\_\_\_\_
- How long does it last? \_\_\_\_\_
- Muscle weakness

## NEUROLOGIC

- Decreased memory
- Dizziness
- Fainting
- Headaches
- Muscle Spasm
- Seizures
- Numbness/tingling in hands or feet
- Spinning sensation
- Slurred speech
- Sudden loss or "greying" of vision in one eye, "like a curtain"

## PSYCHIATRIC

- Anxiety
- Depression
- Frequent crying
- Hallucinations
- Nervousness
- Feelings of unreality
- Have been under psychiatric care
- When? \_\_\_\_\_

## ENDOCRINE

- Change in skin color
- Feel cold all the time
- Feel hot all the time
- Hypothyroid

## HEMATOLOGIC

- Anemia
- Bleeding tendency
- Low platelets
- Low white blood cells

# Comprehensive Initial History

## PROBLEM LIST/ PAST MEDICAL (Please indicate all that apply to you)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Leukemia          | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Aorta problems    | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Lupus             | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Lyme disease      | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Miscarriages      | <input type="checkbox"/> Sarcoidosis          |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Nervous condition | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Osteoarthritis    | <input type="checkbox"/> Stomach ulcers       |
| <input type="checkbox"/> Cataracts         | <input type="checkbox"/> Hypothyroid             | <input type="checkbox"/> Osteoporosis      | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Jaundice/ Liver Colitis | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> COPD              | <input type="checkbox"/> Kidney disease          |  |   |

List hospitalizations or major illnesses not listed above: \_\_\_\_\_

List motor vehicle accidents in which you were injured, and type of injury: \_\_\_\_\_

List fracture or serious injures not already listed above: \_\_\_\_\_

List operations not listed above: \_\_\_\_\_

## ALLERGY

Do you have any allergies to any medications?

- NO  
 YES

Medication

Reaction

_____	_____
_____	_____
_____	_____

## FAMILY HISTORY: (Indicate all that apply to a blood relative, and indicate their relationship to you. (Mother, father, sister, etc.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia _____                | <input type="checkbox"/> Gout _____                | <input type="checkbox"/> Rheumatic fever _____      |
| <input type="checkbox"/> Aorta Problems _____        | <input type="checkbox"/> Heart disease _____       | <input type="checkbox"/> Rheumatoid arthritis _____ |
| <input type="checkbox"/> Asthma _____                | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Sarcoidosis _____          |
| <input type="checkbox"/> Bleeding Tendency _____     | <input type="checkbox"/> Lupus _____               | <input type="checkbox"/> Scleroderma _____          |
| <input type="checkbox"/> Cancer _____                | <input type="checkbox"/> Marfan syndrome _____     | <input type="checkbox"/> Stroke _____               |
| <input type="checkbox"/> Chronic low back pain _____ | <input type="checkbox"/> Osteoarthritis _____      | <input type="checkbox"/> Thyroid disease _____      |
| <input type="checkbox"/> COPD _____                  | <input type="checkbox"/> Osteoporosis _____        | <input type="checkbox"/> Tuberculosis _____         |
| <input type="checkbox"/> Crohn's Disease _____       | <input type="checkbox"/> Psoriasis _____           | <input type="checkbox"/> Ulcerative colitis _____   |
| <input type="checkbox"/> Diabetes _____              |  |   |

## SOCIAL HISTORY

### Currently Working (Check all that apply)

- Full-time  
 Part-time (Hours per week: \_\_\_\_\_ )  
 Self-employed  
 Full-time parent

Occupation: \_\_\_\_\_

### Not Currently Working (Check all that apply)

- Retired  
 Unemployed, looking for work  
 Unemployed, not looking for work  
 Disabled (Date and reason: \_\_\_\_\_ )  
 Other: \_\_\_\_\_

If you believe you are unable to work for medical reasons, please list those reasons: \_\_\_\_\_

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Do you have a lawsuit pending for disability, accident, or worker's compensation? \_\_\_\_\_

Have you applied for disability or workers compensation? \_\_\_\_\_

Have you ever been exposed to lead, asbestos, arsenic or other industrial hazard? \_\_\_\_\_

Do you Smoke?

- No  
 Yes (Frequency and amount: \_\_\_\_\_ )

Former Smoker?  No  Yes (When did you quit? \_\_\_\_\_ )

Do you consume alcohol?

- No  
 Yes ( Less than once a month  Less than once a week  1-4 days a week  More than 4 days a week)

Have you used illegal drugs in the past two years?

- No  
 Yes \_\_\_\_\_

Living Situation

Residence Type:  House  Apartment  Mobile Home

Do you have stairs to climb?  No  Yes (How many flights? \_\_\_\_\_)

How many people live in your home? \_\_\_\_\_

**Medications** (Indicate any of the following medications you've taken)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Actemra                    | <input type="checkbox"/> Aleve (naproxen)                | <input type="checkbox"/> Allopurinol (zylorim)        |
| <input type="checkbox"/> Aralen (chloroquine)       | <input type="checkbox"/> Aspirin (anacin, ecotrin, etc.) | <input type="checkbox"/> Azulfidine (sulfasalazine)   |
| <input type="checkbox"/> Benlysta                   | <input type="checkbox"/> Cellcept                        | <input type="checkbox"/> Cimzia                       |
| <input type="checkbox"/> Cosentyx                   | <input type="checkbox"/> Colchicine                      | <input type="checkbox"/> Cyclosporine                 |
| <input type="checkbox"/> Cytoxan (cyclophosphamide) | <input type="checkbox"/> Enbrel                          | <input type="checkbox"/> Gold (shots or pills)        |
| <input type="checkbox"/> Humira                     | <input type="checkbox"/> Imuran (azathioprine)           | <input type="checkbox"/> Indocin (indomethacin)       |
| <input type="checkbox"/> IVIg                       | <input type="checkbox"/> Leflunomide (Arara)             | <input type="checkbox"/> Lodine (etodolac)            |
| <input type="checkbox"/> Methotrexate (rheamatrex)  | <input type="checkbox"/> Motrin, Advil (ibuprofen)       | <input type="checkbox"/> Naprosyn, Anaprox (naproxen) |
| <input type="checkbox"/> Oencia                     | <input type="checkbox"/> Plaquenil (hydroxychloroquine)  | <input type="checkbox"/> Prednisone, Medrol           |
| <input type="checkbox"/> Probenecid (benemid)       | <input type="checkbox"/> Relafen (nabumetone)            | <input type="checkbox"/> Remicade                     |
| <input type="checkbox"/> Rituxan                    | <input type="checkbox"/> Stelara                         | <input type="checkbox"/> Simponi                      |
| <input type="checkbox"/> Toradol (ketorolac)        | <input type="checkbox"/> Tylenol (acetaminophen)         | <input type="checkbox"/> Xeljanz                      |

Please indicate which of the above medications you are **currently** taking, and list any others you're taking below:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Health Assessment Questionnaire Disability Index (HAQ-DI)©

Name \_\_\_\_\_

Date \_\_\_\_\_

## YOUR HEALTH

Please rate how well you are doing on a scale of 0 to 100  
*(0 represents "very well" and 100 represents "very poor" health)*  
 Please record the number below.

Record 0 to 100 here: \_\_\_\_\_

**Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:**

	WITHOUT ANY DIFFICULTY 0	WITH SOME DIFFICULTY 1	WITH MUCH DIFFICULTY 2	UNABLE TO DO 3
<b><u>DRESSING &amp; GROOMING</u></b>				
<b>Are you able to:</b>				
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>ARISING</u></b>				
<b>Are you able to:</b>				
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EATING</u></b>				
<b>Are you able to:</b>				
Cut your own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>WALKING</u></b>				
<b>Are you able to:</b>				
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please check any AIDS OR DEVICES that you usually use for any of the above activities:**

- |  |   |
|--|---|
| <input type="checkbox"/> Devices used for dressing (button hook, zipper pull, etc)<br><input type="checkbox"/> Special or built up chair<br><input type="checkbox"/> Built-up or special utensils<br><input type="checkbox"/> Crutches | <input type="checkbox"/> Cane<br><input type="checkbox"/> Walker<br><input type="checkbox"/> Wheelchair |
|--|---|

**Please check any categories for which you usually need HELP FROM ANOTHER PERSON:**

- Dressing and grooming   
  Arising   
  Eating   
  Walking

**Please place an “x” in the box which best describes your abilities OVER THE PAST WEEK:**

WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
0	1	2	3

**HYGIENE**

**Are you able to:**

Wash and dry your body?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Take a tub bath?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Get on and off the toilet?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**REACH**

**Are you able to:**

Reach and get down a 5 pound object (such as a bag of sugar) from above your head?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Bend down to pick up clothing from the floor?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**GRIP**

**Are you able to:**

Open car doors?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Open previously opened jars?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Turn faucets on and off?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**ACTIVITIES**

**Are you able to:**

Run errands and shop?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Get in and out of a car?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Do chores such as vacuuming or yard work?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**Please check any AIDS OR DEVICES that you usually use for any of the above activities:**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Bathtub seat | <input type="checkbox"/> Long-handled appliances in bathroom | <input type="checkbox"/> Jar opener (for previously opened jars) |
| <input type="checkbox"/> Bathtub bar  | <input type="checkbox"/> Long-handled appliances for reach   | <input type="checkbox"/> Raised toilet seat                      |

**Please check any categories for which you usually need HELP FROM ANOTHER PERSON:**

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> Hygiene | <input type="checkbox"/> Gripping and opening things |
| <input type="checkbox"/> Reach   | <input type="checkbox"/> Errands and chores          |

**Your ACTIVITIES:** To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- |                                     |                                 |                                     |                                   |                                     |
|-------------------------------------|---------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Completely | <input type="checkbox"/> Mostly | <input type="checkbox"/> Moderately | <input type="checkbox"/> A Little | <input type="checkbox"/> Not at all |
|-------------------------------------|---------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|

# ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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, disclosed, and how I may get access to this information. I have also been given the opportunity to take the copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected medical information, i.e. Lab results and billing issues, you can either leave a message or discuss my information with the following individual(s):

NAME	RELATIONSHIP

**By signing below, I agree to the fore mentioned statement.**

Patient/ Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Practice Representative: \_\_\_\_\_ Date: \_\_\_\_\_

## Automated Confirmation Notice

In order to better serve you, we have an automated appointment reminder system to provide you with the courtesy of a timely, efficient reminder of your next scheduled appointment.

You will receive a call two (2) days prior to your appointment to inform you of vital information, such as the name of your provider, the date, location, and time of your appointment. You will also be able to confirm or cancel by using your telephone keypad and pressing the following keys anytime during the message. We would greatly appreciate your response.

Press 1 to Confirm  
Press 2 to repeat the message  
Press 5 to cancel

If you are unavailable when the call is made and have voicemail or an answering machine, the system will leave you a brief message. If you receive this message or fail to press the correct key, please contact our office at 423-794-3040 to confirm or cancel your appointment.

Thank you.

# 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 MSJC'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.
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 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 satisfactory payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

Patient Name: \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Notice of Nondiscrimination

State of Franklin Healthcare Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. State of Franklin Healthcare Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### State of Franklin Healthcare Associates:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats, other formats)
  
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

**If you need these services, please contact the Office Manager.**

**If you believe that State of Franklin Healthcare Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:**

**Vicki Moody**  
**2528 Wesley Street, Suite 2**  
**Johnson City, TN 37601**  
**P: 423.794.2440**  
**F: 423-283.9730**  
**[vickimoody@sofha.net](mailto:vickimoody@sofha.net)**

or

**Sandra Westelaken**  
**2528 Wesley Street, Suite 1**  
**Johnson City, TN 37601**  
**P: 423.794.2435**  
**F: 423.794.1842**  
**[sandrawestelaken@sofha.net](mailto:sandrawestelaken@sofha.net)**

**You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Vicki Moody or Sandra Westelaken are available to help you.**

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019; 1-800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>