Blue Ridge Family Medicine

Patient Registration Form

****PLEASE COMPLETE AND SIGN AT THE BOTTOM****

Name_____
Last *First* *Middle*

Home Address *(must include street address)* _____

_____City _____ State _____ Zip code _____

Home phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

E-mail Address _____

Birthdate: ___/___/____ Sex: M or F Marital Status _____

Race: _____ Hispanic/Non-Hispanic Language: _____

Social Security # _____

Employer _____

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

Name_____ Relationship to patient_____
Last *First* *Middle*

Social Security # _____ Home phone_____Cell Phone _____

Mailing Address

_____ City _____ State _____ Zip code _____

Employer _____ City _____ State _____

Emergency Contact Information

Name_____ Phone_____ Relationship to patient _____

Insurance information

Name of Primary Insurance _____ Subscriber ID# _____

Policy Holder _____ Birth date _____Group # _____
(Name on insurance card)

Name of Secondary Insurance _____ Subscriber ID# _____

Policy Holder _____ Birth date _____ Group # _____
(Name on insurance card)

_____ _____
Patient (or guardian) Signature Date

_____ _____
Patient Name (please print) 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

BLUE RIDGE FAMILY MEDICINE
301 Med Tech Parkway, Ste. 120
Johnson City, TN 37604
423-794-1800 / 423-794-1801 (fax)

HELP US HELP YOU!

New Phone Number: 423-794-1800
Please begin using our new number as our old number will stop forwarding to us in the near future.

Insurance Coverage: No matter how hard we try, we simply cannot keep up with all the insurance plans and subtypes with which our patients present. In fact, your insurance cannot discuss your plan with us unless you are present due to HIPAA regulations.

You will experience less headaches and less incorrect billings from our office if you know the following information prior to your visit to our office:

- Is an annual physical covered?
- What are your benefits as they relate to routine exams?
- What is your copay?
- What are your individual and/or family deductible amounts?
- Do you have pre-existing waiting periods?
- Which Prescriptions are covered (Generics vs. Brand Name)
- The first visit with a new physician is to establish care only. **(not a physical)**

You are given an insurance membership handbook and ID card at the time you become a participating member of your insurance company. All the above information is contained in that handbook.

Medication Refills: We are now refilling prescriptions at the time of your visit, so please make an appointment when you are low on your medications and BRING YOUR MEDICATIONS AND THEIR BOTTLES WITH YOU to your appointment. In a situation that seriously endangers your health, we will call or fax in a refill to your pharmacy. However, we need 48-72 hours notice to fill these. We will not be able to fill medications the same day unless you are here for an appointment.

Referrals: We attempt to complete all referrals as soon as possible, however, the process is often lengthy due to insurance requirements and the availability of the scheduling staffs of those we refer to. Except in situations when your health is seriously endangered, we require 5 business days notice to complete the referral. We cannot complete referrals the same day. We suggest you call your specialist the week prior to your appointment to confirm receipt of your referral.

Please understand we strive to provide the best patient care possible, so when challenges arise, we can and will find ways to overcome them. For this reason, we are asking you to please read and sign the following statement acknowledging your understanding of our policies regarding insurance benefits, medication refills, and referrals. Thank you.

I have read and understand this disclaimer from Blue Ridge Family Medicine.

*Patient 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

Today's Date ___/___/___

NOTE: PLEASE COMPLETELY FILL OUT FORM.

Personal Health History

Name_____ **Sex: M F Age**____ **D.O.B**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Street Address_____**APT.#**_____

City_____ **State**_____ **Zip Code**_____

E-mail address_____

How did you hear about us?_____

Pharmacy:_____**Address**_____
Phone #_____

Advance Directives

Do you have a living will? Yes_____ No_____ If not, please notify us and we will provide an information packet 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	Physcian	Facility
1.)				
2.)				
3.)				
4.)				
5.)				
6.)				
7.)				
8.)				
9.)				
10.)				

Other Providers: **Phone/Fax Number** **Specialty**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you ever had a blood transfusion? Yes_____ No_____

Immunizations		**Date**	**Location Given**
Pneumonia	Yes____ No____	____/____/____	_____
Prevnar	Yes____ No____	____/____/____	_____
Flu	Yes____ No____	____/____/____	_____
Tetanus	Yes____ No____	____/____/____	_____

Occupational History

List any toxic or chemical exposures, coal mining, sandblasting, asbestos or any other occupational hazards_____

Women's Health

Number of Pregnancies_____ Children Born_____ Miscarriages/abortions_____
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: Single____ Married____ Divorced____ Widowed____ What Year?____
Spouse's name_____ Church/Religious affiliation_____
Tobacco Use: Smoker___ Former Smoker____ Never Smoker____
Packs per day____ Smoked for how many years?_____
Smokeless Tobacco: Snuff____ Chewing Tobacco____ How much_____
Alcohol Use: How many drinks per day___ week___ Drinking for how many years_____
Do you wear you seat belts? Yes____ No____
Exercise: None____ Every other day____ 3-4 times per week____ Daily____

Sexual Orientation

How do you define your sexual orientation?
Heterosexual____ Homosexual_____ Bisexual_____ Transgender____
I do not wish to disclose_____

Medications:

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

Family Hx: Major Illnesses or Cause of Death

Please list family member's diseases and cause of death.

Hrt Disease * Diabetes* Obesity* High Blood Pressure* Cholesterol* Cancer* Lung disease * Thyroid

	Age of Death	Living/ Deceased
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sister		
Sister		
Brother		
Brother		
Son		
Son		
Daughter		
Daughter		

Medical History

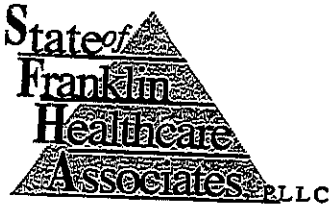
___Diabetes
___Thyroid Disease
___High Blood Pressure
___Heart Attack
___Heart Failure
___Angina (chest pain)
___Heart Rhythm Problem
___Heart Murmur
___Rheumatic Fever
___High Cholesterol
___ Lung Disease
___COPD/Emphysema
___Pneumonia
___Tuberculosis
___Alcoholism
___Depression
___Drug Abuse
___Nervous Breakdown

___Asthma
___Bronchitis
___Seasonal Allergies
___Colitis, Bowel Disease
___Liver disease
  ___Hepatitis
  ___Cirrhosis
___Gallbladder Disease
___Anemia
___Easy Bleeding
___Blood Clots
___Cancer or Tumor
___Eye Disease
___Glaucoma
___Cataract
___Suicide Attempt
___Ear Disease

___ Sinus Problems
___Ulcers
___Skin Problems
___Chronic Headaches
___Seizures
___Stroke
___Paralysis
___Arthritis
___Lupus
___Bone Fracture
___Muscular Problems
___Kidney Stones
___Bladder Infections
___Prostate Problems
___Urinary Problems
___ Sexually Transmitted Disease
___Psychiatric disorder
  ___Depression
  ___Anxiety
  ___Bipolar Disorder

Date _____

Patient ID _____



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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

Updated 8/19/10 JMS

State of Franklin Healthcare Associates, PLLC

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Peripheral Arterial Disease Questionnaire

This questionnaire is a screening tool for Peripheral Arterial Disease (P.A.D.). As a proud member of the P.A.D. Coalition, we are committed to detecting and treating P.A.D. for our patients. Based on your answers, we may or may not recommend additional testing to determine if you in fact have the disease. By filling out this questionnaire, you are helping us remember to obtain the information listed below that we may otherwise forget to ask. **Feel free to leave answers blank if you are unsure of the answer. A nurse will assist you with the question.**

NAME:_____ DATE: _____

D.O.B. _____ AGE IN YEARS: _____

1. If you age 70 or older, you may stop here.

2. If you are age 50-69, do you have diabetes? *yes* *no*

3. If you are age 50-69, do you smoke? *yes* *no*

4. If you are age 50-69, do you have hypertension or high blood pressure? *yes* *no*

5. If you are age 50-69, do you have high cholesterol? *yes* *no*

6. Do you have pain in your leg or legs with walking? *yes* *no*

7. Do you have Coronary (heart), Carotid, or Renal Artery Disease)? *yes* *no*

8. Do you have cool or cold feet? *yes* *no*

9. Do you have pale, blue or other discoloration to the feet? *yes* *no*

10. Do you have a poor pulse in the feet? *yes* *no*

11. Do you have a family history of Vascular Heart Disease? *yes* *no*