



**Blue Ridge Family Medicine
Patient Registration Form**

Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Cell Phone: _____ Sex: Male/Female E-Mail Address: _____

Date of Birth: _____ 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: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Employer: _____

Social Security #: _____ Date of Birth: _____

Insurance Information

Name of Primary Insurance: _____ Subscriber ID#: _____

Policy Holder: _____ Date of Birth: _____ Group #: _____

Name of Secondary Insurance: _____ Subscriber ID#: _____

Policy Holder: _____ Date of Birth: _____ Group #: _____

Emergency Contact Information

Name: _____

Relationship to patient: _____ Home Phone: _____ Cell Phone: _____

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, Master Card, 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 us in filing your insurance.

We are participating providers with the Medicare Program. We will file your charges with Medicare and your Medicare supplement insurance policy. If you do not have a Medicare supplement 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 the time of service. We will file claims with 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 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 acct. If such problems arise, we encourage you to contact us promptly for assistance at 423-794-1800.

Signature: _____ Date: _____

Witness: _____ Date: _____



**Blue Ridge Family Medicine
Acknowledgement 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 and discussed 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.

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

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____

By signing below, I agree to the aforementioned statements.

Signature: _____ Date: _____
Patient or Guardian Signature

If Guardian relationship to patient: _____

Patient Name: _____ DOB: _____
Please Print

Practice Representative: _____ Date: _____

Access your medical information online, 24/7 anywhere, anytime

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: _____



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 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 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.

_____ Date: _____
 Patient Signature or Guardian/Representative



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 Healthcare? 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 Date: _____ Flu Date: _____ Tetanus Date: _____

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 perform regular self-breast exams? Yes/No

Social History

Occupation: _____

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): Yes / No 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 ___ 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 cause of death |
|--------------|-------|--------|-----------------|-----------------------------------|
| Mother | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ |
| Sister (s) | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Brother (s) | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Daughter (s) | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Son (s) | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |

Medical History

Please check if you have had any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Disease | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Colitis, Bowel Disease | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Liver Disease, Hepatitis | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart Rhythm Problem | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Muscular Problems | _____ |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney Stones | _____ |



List of Other Providers Who Treat You

| | Name | Specialty | Phone/Fax Numbers |
|----|-------------|------------------|--------------------------|
| 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. | _____ | _____ | _____ |
| 20. | _____ | _____ | _____ |



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.

Musculoskeletal:

- 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



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., Suite2, 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.

Patient Signature: _____ Date: _____
or (legal rep.): _____

Relationship to patient: _____

Signature of Witness: _____ Date: _____

Patient Acct # _____ Date: _____