



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: _____

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"/> Orencia | <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 list each of the above medications and the **dosages** 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
<u>DRESSING & GROOMING</u>				
Are you able to:				
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"/>
<u>ARISING</u>				
Are you able to:				
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"/>
<u>EATING</u>				
Are you able to:				
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"/>
<u>WALKING</u>				
Are you able to:				
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)
<input type="checkbox"/> Special or built up chair
<input type="checkbox"/> Built-up or special utensils
<input type="checkbox"/> Crutches | <input type="checkbox"/> Cane
<input type="checkbox"/> Walker
<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"/>
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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"/>
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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

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 (i.e. cell phone, private work number) may we try to reach you to leave a message?

_____ Cell phone Work Other: _____

May we mail your appointment or test results to your home address? Yes No

Emergency Contact Number other than YOUR home phone number: (Please note, you are giving permission for this emergency contact to receive your personal health information if necessary.)

Name: _____ Phone Number: _____

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.

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

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

By signing below, I agree to the fore mentioned statements.

_____ Print Patient Name _____ Cell _____ Date of Birth _____

_____ Patient or Guardian Signature _____ Date _____

_____ Practice Representative Signature _____ Date _____

ACCESS YOUR MEDICAL INFORMATION ONLINE, 24/7 ANYWHERE, ANYTIME!

YES! I would like to enjoy the benefit of accessing my personal health information, or that of my child, online through FollowMyHealth® Email Address: _____

Teaching Physicians: This practice may participate in training new physicians. If so, you may be seen by a physician who is a member of a James H. Quillen College of Medicine Facility. The teaching physicians who work in this office are responsible for teaching residents (postgraduate trainees). Not only will you be seen by your own physician, you may also be seen by one or more residents. We believe this adds to the depth and level of care the patient receives since patients are seen by one or more physicians and then discussed in detail. We are pleased with your willingness to participate in our teaching program. Your care will encompass a team approach to healthcare with involvement of your physician and residents. Please Initial: _____



**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, American Express and Care Credit. In an effort to simplify the payment process, we provide a convenient, highly secure Credit/Debit/HSA card and Bank ACH payment program. You will be asked to provide a card-on-file (card/ACH-based) assurance at the time of service. After the insurance claim has been filed (if applicable), we will send you an electronic bill of your final financial responsibility. Your card-on-file will be charged for your out-of-pocket responsibility after the notice period and an electronic receipt will be emailed to you.

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. This will remain in effect until revoked in writing.

Patient Name

Patient Date of Birth

Patient or Guardian Signature

Date