Medical Specialists
OF JOHNSON CITY

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)

Reason for your Visit

Please indicate all that apply to you.

- □ Ankle Pain
- □ Arm Pain
- □ Arthritis
- □ Back Pain
- □ Calf Pain
- □ Decreased joint range of motion
- □ Elbow pain
- □ Finger Problems
- □ Foot Pain
- □ Foot Problems
- □ Hand Pain
- □ Hip Pain
- □ Joint Pain
- □ Joint Redness
- □ Joint Stiffness
- □ Joint Swelling
- □ Knee Pain
- □ Leg Pain
- □ Low Back Pain
- □ Muscle Atrophy
- □ Muscle weakness
- □ Myalgia
- □ Neck Pain
- □ Neck Stiffness
- □ Osteomyelitis
- □ Osteoporosis
- □ Pinched Nerve
- □ Post Fracture
- □ Pseudo Gout
- □ Radiating Leg Pain
- □ Rheumatoid Arthritis
- □ Shoulder Pain
- □ Spondylolisthesis
- □ Weakness
- □ Wrist Pain

Other / Additional Details: _____

_____

_____

_____

_____

_____

_____

ONSET: How long have you been experiencing these symptoms? _____

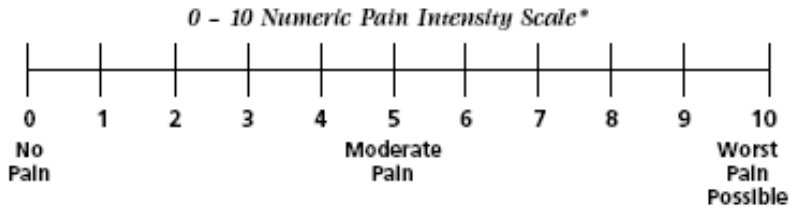
TIMING: How frequently are you experiencing these symptoms?

____ Constantly ____ Frequently ____ Intermittently ____ Occasionally ____ Rarely ____ Daytime ____ Nocturnally

SEVERITY: What is the severity of you symptoms? ____ Mild ____ Moderate ____ Severe

Are you having pain now? _____ Yes _____ No

Please rate your pain on the scale to the right.



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

GENITOURINARY

□ 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)

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

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.)

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

SOCIAL HISTORY

Currently Working (Check all that apply)	**Not Currently Working** (Check all that apply)
□ Full-time	□ Retired
□ Part-time (Hours per week: _____)	□ Unemployed, looking for work
□ Self-employed	□ Unemployed, not looking for work
□ Full-time parent	□ Disabled (Date and reason: _____)
Occupation: _____	□ 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)

□ Actemra	□ Aleve (naproxen)	□ Allopurinol (zylorim)
□ Aralen (chloroquine)	□ Aspirin (anacin, ecotrin, etc.)	□ Azulfidine (sulfasalazine)
□ Benlysta	□ Cellcept	□ Cimzia
□ Cosentyx	□ Colchicine	□ Cyclosporine
□ Cytoxan (cyclophosphamide)	□ Enbrel	□ Gold (shots or pills)
□ Humira	□ Imuran (azathioprine)	□ Indocin (indomethacin)
□ IVIg	□ Leflunomide (Arara)	□ Lodine (etodolac)
□ Methotrexate (rheamatrex)	□ Motrin, Advil (ibuprofen)	□ Naprosyn, Anaprox (naproxen)
□ Orencia	□ Plaquenil (hydroxychloroquine)	□ Prednisone, Medrol
□ Probenecid (benemid)	□ Relafen (nabumetone)	□ Remicade
□ Rituxan	□ Stelara	□ Simponi
□ Toradol (ketorolac)	□ Tylenol (acetaminophen)	□ 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
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

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

- □ Devices used for dressing (button hook, zipper pull, etc)
- □ Special or built up chair
- □ Built-up or special utensils
- □ Crutches
- □ Cane
- □ Walker
- □ 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 0	WITH SOME DIFFICULTY 1	WITH MUCH DIFFICULTY 2	UNABLE TO DO 3
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

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

- ☐ Bathtub seat
- ☐ Bathtub bar
- ☐ Long-handled appliances in bathroom
- ☐ Long-handled appliances for reach
- ☐ Jar opener (for previously opened jars)
- ☐ Raised toilet seat

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

- ☐ Hygiene
- ☐ Reach
- ☐ Gripping and opening things
- ☐ 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?

- ☐ Completely
- ☐ Mostly
- ☐ Moderately
- ☐ A Little
- ☐ Not at all

State of Franklin HEALTHCARE ASSOCIATES™

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

State of Franklin
HEALTHCARE ASSOCIATES

Acknowledgment 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 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. May we contact you at any of the following numbers and leave a message on an answering machine or with a family member/friend regarding your appointment or test results (check all that apply)?

☐ Yes, cell phone: _____
☐ Yes, home phone: _____
☐ Yes, work phone: _____
☐ No

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

---

II. Emergency Contact Number other than YOUR home phone number: (Please note, you are giving permission for this contact to receive your personal health information in the event of an emergency .)

Name:_____ Phone Number: _____

III. Please provide the names of others involved in your care that you would like for us to communicate with, if necessary. If none, please leave blank.

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

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

_____ _____ _____
Print Patient Name Cell Number Date of Birth

_____ _____
Patient/Parent or Guardian Signature Date

_____ _____
Practice Representative Signature Date

State of Franklin
HEALTHCARE ASSOCIATES

Access Your Records Anytime

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

With FollowMyHealth, you can:

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results
- Read medical notes from your doctor
- Request updates to your health information (allergies, medications, conditions, etc.)
- Request Rx refills
- Request appointments
- Set up proxy accounts for children and dependent adults
- And more!

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

*If you would like to sign your child up for FollowMyHealth and they are between the ages of 14 and 17, please see the front desk. There is an additional form that you must complete in order to have access to their account.

☐ **Teaching Physicians and Other Medical Students:** This practice may participate in training new physicians, nurses, and other medical students. As a result, you may be seen by multiple individuals at one time, such as a nurse and trainee or your personal physician and 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 or nurses and then discussed in detail. We appreciate your willingness to participate in our teaching program. **Please Initial:** _____

Please print name: _____
Date of birth: _____