Mountain Region Family Medicine

Patient Information

Patient # _____

(Please print)

Legal Name _____

First Middle Last

Preferred name/ Nickname _____

Date of Birth _____ Sex _____ Male _____ Female

Race_____

Primary Language _____ Religion _____

Marital Status _____ Driver's License No. _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Please circle preferred communication: Cell Phone Home Phone Work Phone Mail

Email/Patient Portal **PLEASE FOLLOW INSTRUCTIONS TO ENROLL IN PATIENT PORTAL ON OUR WEBSITE AT MRFM.NET**

Preferred Pharmacy- Local _____

Preferred Pharmacy- Mail Order _____

Employer _____

Employer Address _____

Emergency Contact _____

Relationship/Phone Number _____

PLEASE MAKE AVAILABLE YOUR INSURANCE CARD/CARDS AND YOUR DRIVERS LICENSE FOR US TO COPY INTO YOUR PATIENT RECORD. THANK YOU.

OVER >

Consent to Release Information

Patient # _____

I, _____, give the physicians and office staff of Mountain Region Family Medicine permission to discuss my medical condition with:

With: _____

Who is: _____ Phone: _____

(Relationship)

With: _____

Who is: _____ Phone: _____

(Relationship)

With: _____

Who is: _____ Phone: _____

(Relationship)

I further give consent to share my medical record electronically with other physicians that I may consult with and with the hospital where I may be admitted or have test performed. I understand these records will be transferred under the strictest HIPPA guidelines and no financial or personal information will be shared.

Signature _____

May we confirm appointments by answering machine? _____

May we leave test results on your answering machine? _____

May we contact you at work? _____

May we look up prescription benefits, only if there should be a need for this? Yes No

_____ _____

Patient Signature Date

This is an indefinite consent form unless otherwise specified.

Medical History

Name: _____ DOB: _____ Today's Date: _____

Current Medical Problems:

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

Past Medical Hospitalizations: (Please list reason and year.)

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

Surgeries: (Please list procedure and year.)

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

Medications: (Include strength and how taken.)

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

Medication Allergies:

_____

_____

Family History: (Please circle all that apply.)

Diabetes (adult onset)	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Diabetes (juvenile onset)	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
High Blood Pressure	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Heart Disease	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Stroke	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Breast Cancer	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Colon Cancer	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Prostate Cancer	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Alzheimers	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling
Other _____	Fath	Moth	Broth	Sis	GrandPar	Aunt	Uncle	>1Sibling

Father: Healthy Poor health Deceased Age:_____

Mother: Healthy Poor health Deceased Age:_____

Number of sisters born _____ Number of sisters living _____

Number of brothers born _____ Number of brothers living _____

General

Yes	No	Unusual persistent fatigue
Yes	No	General malaise
Yes	No	Unintended weight gain
Yes	No	Unintended weight loss
Yes	No	Night sweats

Eyes/Ears

Yes	No	Sudden visual change
Yes	No	Eye pain

Cardiovascular

Yes	No	Chest pain with exertion
Yes	No	Shortness of breath lying down
Yes	No	Episodes of shortness of breath
Yes	No	Palpitations
Yes	No	History of heart murmur
Yes	No	History of rheumatic fever
Yes	No	Calf/thigh pain with walking
Yes	No	History of previous heart attack

Yes No Eye discharge/drainage

Yes No Wear glasses to read only

Yes No Wear glasses (at all times)

Yes No Double vision

Yes No Sudden change of hearing

Yes No Ear pain

Yes No Ear drainage/discharge

Yes No Frequent ear infections

Yes No Ringing in the ear(s)

Yes No Use hearing aids

Nasal/Sinus

Yes No Persistent nasal congestion

Yes No Persistent nasal discharge

Yes No Allergic rhinitis

Yes No Chronic sinus infections

Oral/Pharynx

Yes No Mouth sores

Yes No Gum pain

Yes No Toothache

Yes No Wear dentures

Yes No Dry mouth

Yes No Sore throat

Yes No Post-nasal drainage

Yes No Hoarseness

Yes No Difficulty swallowing

Yes No Bad breath

Respiratory

Yes No History of high blood pressure

Gastrointestinal

Yes No Frequent/chronic indigestion

Yes No Acidic reflux/backwash

Yes No Difficulty swallowing

Yes No Persistent abdominal pain

Yes No History of ulcers

Yes No Frequent vomiting

Yes No Persistent diarrhea

Yes No Persistent constipation

Yes No Recent change in bowels

Yes No Rectal bleeding/blood in stool

Yes No Black stool

Yes No Hemorrhoids

Yes No Rectal pain

Yes No History of hepatitis

Dematologic

Yes No Persistent rash

Yes No Psoriasis

Yes No Itching

Yes No Changing mole

Yes No Previous skin cancer

Urinary

Yes No Pain with urination

Yes No Urinary frequency

Yes No Up >1 time at night to urinate

Yes No Blood in urine

Yes No Chronic cough

Yes No Daily productive cough

Yes No Short of breath with activity

Yes No Short of breath at rest

Yes No Coughing up blood

Yes No Wheezing

Yes No Asthma

Yes No Recurrent bronchitis

Yes No Recurrent pneumonia

Female Only

Yes No Unexpected vaginal bleeding

Yes No Gone through menopause

Yes No Irregular menstrual periods

Yes No Excessively painful periods

Yes No Previous hysterectomy

Yes No Persistent pelvic pain

Yes No Breast lump

Yes No Breast discharge

Yes No Breast pain

Endocrine

Yes No Unusual hair loss

Yes No Excessive thirst

Yes No Unusally hot or cold

Yes No Flushing

Yes No History of goiter

Yes No Persistent back pain

Yes No Migraine headaches

Yes No History of kidney stones

Male only

Yes No Discharge from penis

Yes No History of recurrent prostate inf

Yes No History of enlarged prostate

Yes No Inadequate erections

Allergic/Immune

Yes No Allergy problems

Yes No Recurrent hives

Yes No Hay fever

Yes No Taking prednisone

Yes No Recurrent infections

Hematologic/Lymph

Yes No Easy bruising

Yes No Bleeding gums

Yes No Enlarged lymph nodes

Yes No Immune deficiency

Yes No History of anemia

Yes No Blood disorder

Musculoskeletal

Yes No Joint pain

Yes No Swollen joints

Neurologic

Yes No Persistent muscle pain

Yes No Persistent neck pain

Yes No History of osteoporosis

Yes No Muscle weakness

Yes	No	Tension or other frequent headaches	**Psychiatric**		
Yes	No	Recurrent fainting	Yes	No	History of Anxiety
Yes	No	History of seizure	Yes	No	History of depression
Yes	No	Foot or leg numbness	Yes	No	Trouble sleeping
Yes	No	Numbness of foot or am	Yes	No	Frequent crying
Yes	No	Dizziness	Yes	No	Panic attacks
Yes	No	Trouble with balance	Yes	No	Loss of interest in sex
Yes	No	Tremor	Yes	No	History of alcohol abuse
Yes	No	Previous stroke	Yes	No	History of drug abuse

Maritial Status: Married Single Divorced Widowed

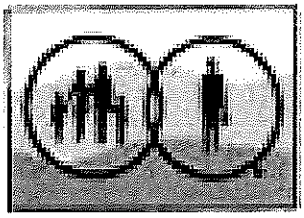
Employment: Full time Part time Unemployed Full time student

Homemaker Retired

Occupation: _____

Do you smoke cigarettes?	Yes	No	If so, how many packs per day? _____		
Do you smoke cigars or a pipe?	Yes	No	If so, how many per day? _____		
Do you chew tobacco or dip?	Yes	No	If so, how many times per day? _____		
Do you drink alcoholic beverages?	Never	Rarely	Occasionally	Frequently	# per week _____
Do you smoke marijuana?	Never	Rarely	Occasionally	Frequently	
Do you use cocaine or other drugs?	Never	Rarely	Occasionally	Frequently	
Do you currently use IV drugs?	Never	Rarely	Occasionally	Frequently	
Have you ever used IV drugs?	Yes	No			
Do you wear seatbelts when driving?	Yes	No			
Do you exercise regularly?	Yes	No			

Colonial Heights



Mountain Region
FAMILY
MEDICINE, P.C.

Colonial Heights - 101 Professional Park - Kingsport, Tennessee 37663 - (423) 239-7300 - Fax (423) 239-8581

1. Receipt of Privacy Notice
and
2. Special Privacy Directives

Patient Name: _____ **Date of Birth:** _____

1. Please sign here if you received a copy of our Notice of Privacy Practices. You may also request a copy of our current Notice of Privacy Practices in the future at any time.

I received a copy of the Notice of Privacy of Privacy Practices. **Date signed:** _____

Signature: _____

2. Please indicate below if you have special requests for handling your protected health information (Mountain Region Family Medicine will let you know if it agrees to honor the request.) For example, do you wish to specify people who can be told information about your condition? People who should not be told about your condition? Do you want us to avoid leaving messages about appointments on your phones answering machine?

I request the follow instructions on use or disclosure of my protected health information:

_____

_____

_____

Patient Name (Printed)

Mountain Region
FAMILY
MEDICINE, P.C.

Consent For Treament

1. **General Consent for Treatment and Tests**: I consent to treatment by the Mountain Region Family Medicine physicians, nurse practitioners, and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTESS have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2.**Independently Practicing Doctors**: I understand and agree that most of the radiologists, pathologists, anesthesiologist and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of Mountain Region Family Medicine.I hereby authorized payment directly to these physicians the insurance benefits otherwise payable to me but not to exceed the total charges due to the physicians, I also authorize the release of any medical information necessary to process these insurance claims.

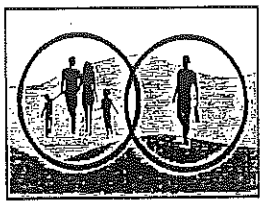
3. **Release from Liability for Leaving Against Medical Advice**: I agree that if I leave a physician's office against the advice of my physician or the Mountain Region Family Medicine staff, then Mountain Region Family Medicine, its personnel, and my physician(s) are released from the responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

4. **Authorization to Release Medical Information**: I authorize Mountain Region Family Medicine and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

5. **Assignment of Insurance Benefits/Promise to Pay**: For and in consideration of services rendered and to be rendered by Mountain Region Family Medicine, I hereby guarantee payment for all charges incurred for the account of the above mentioned patient. I understand and direct any person, firm or corporation, including but not limited to, insurance companies or attorneys representing the patient or any other party, for such services to assign proceeds of any payment for services rendered to said patient directly to Mountain Region Family Medicine. I understand that by Mountain Region Family Medicine accepting assignment of said benefits, the provider does not relinquish its right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection, I will pay reasonable collection fees and attorney fees, interest, court costs and other collection expenses.

I have read and understand this document, and I agree to its terms.

Patient/Authorized Party	Relationship	Date	Witness



Mountain Region
FAMILY
MEDICINE, P.C.

Kingsport • Colonial Heights • Gate City • Nickelsville

MOUNTAIN REGION FAMILY MEDICINE, PC

444 Clinchfield St., Kingsport, TN 37660

NOTICE OF INFORMATION PRACTICES

This Notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive.

This notice gives examples of how we will use or disclose your health information for treatment, payment, and health care operations. The Notice also describes circumstances when we may have to use or disclose the information even without your consent.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your consent for the following purposes:

- *Required by Law*: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities*: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products to public health authorities, and similar information.
- *Health Oversight*: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

AUTHORIZATION FOR RELEASE OF RECORDS

Section A: Must be completed for all authorizations

I herby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to resdisclosure by the recipient and no longer protected by federal privacy regulations.

Patient name:_____ ID Number:_____.

Date of Birth:_____ SSN #:_____.

Providing: _____ Receiving: Mountain Region Family Medicine

_____ 101 Professional Park

_____ Kingsport, TN 37663

_____ Phone (423) 239-7300 Fax (423)2398581

Specific description of information (including date(s)): ALL MEDICAL RECORD and/or

_____

_____

What is the purpose of this disclosure?: CONT. OF CARE and/or

_____

_____

(Note: "At the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement: Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described aboue? Yes _____ No _____

2. The patient must read and initial the following statement:

A: I understand that I get a copy of this form after I sign it. Patient initials: _____

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. Patient initials: _____

I understand that this authorization will expire on the following date ___/___/___ or with the following event: 90 DAYS AFTER DATE OF SIGNATURE.

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. Patient initials: _____

_____ _____

Signature of patient or patient's representative Date

(pertinent sections of the form MUST be completed before signing)

Printed name of patient's representative: _____ Relationship to the patient: _____