GALEN
MEDICAL GROUP

North Internal Medicine
4980 Alpha Lane
Chattanooga, TN 37343
Phone (423) 870-2450 Fax: (423) 877-5208

Appointment Label

Welcome to Galen Medical Group!

Please read and complete the information included in this packet.Each page is necessary for you to complete in order to establish yourself as a New Patient with Galen Medical.

On the day of your appointment, please arrive 20 minutes earlier than your appointment time. This will allow us to enter your new patient data into out Electronic Medial Record (EMR).

Please remember to bring with you the following completed/signed items:

- ☐ Photo ID
- ☐ Insurance(s)
- ☐ Patient Registration Form
- ☐ Missed Appointment Policy
- ☐ Financial Policy
- ☐ Health History Questionnaire
- ☐ Yearly Wellness Form
- ☐ HIPPA forms
- ☐ Medical Records Release Form
- ☐ Living Will / Advanced Directive

We welcome you to our office and look forward to meeting you.

Sincerely,
Shannon Kitchings
Galen Regional Manager

PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

PATIENT INFORMATION:

NAME: _____ GENDER: ❑ Male ❑ Female

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____ E-MAIL: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ _____
Street / P.O. Box / Apt. No. City / State / Zip Code

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

DOMESTIC INFORMATION:

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPERATED ❑ DIVORCED ❑ WIDOWED

SPOUSE/OTHER NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____ _____
Street / P.O. Box / Suite # City / State / Zip Code

PREFERRED LANGUAGE: ***Must list one.*** _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian

❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

SECONDARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

GALEN
MEDICAL GROUP

NORTH INTERNAL MEDICINE

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, we ask that you contact us at least 24 hours in advance. This will allow us to schedule patients that are having acute problems.

New patients that fail to keep their original appointment without notice, or a valid reason, will not be rescheduled with Galen Medical Group North Internal Medicine.

Failure to keep your appointment affects the flow of the office and creates many inconveniences to our patients. We consider a failed appointment to be: canceling on short notice, failing to arrive for an appointment, or appearing too late to be seen.

We will send out a reminder letter when you fail your first appointment. If you continue to fail two additional appointments, you will be dismissed from the practice.

If you are dismissed, we will provide emergency care for 30 days only. During this time, we recommend that you find another physician to provide your care. Upon receiving a signed release of medical information form, we will then transfer your medical records.

Thank you for your cooperation.

_____ _____

Signature of Patient Date

GALEN
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North Internal Medicine
4980 Alpha Lane, Chattanooga, TN 37343
Phone (423) 870-2450 Fax: (423) 877-5208

Welcome and Thank you for choosing Galen Medical North Internal Medicine (NIM) for your health care needs. We appreciate your confidence and are committed to giving you the best quality health care.
To help you better utilize our services, we would like to share with you some of our policies and procedure updates that will become effective January 1, 2017.

Office Hours: 7:30am until 4:30pm Monday through Thursday; Friday 7:30am until 12 noon.

Extended Hours Clinic: 5pm until 8pm Monday through Friday; 11am until 4pm Saturday and Sunday

Insurance: Galen participates in many insurance plans which you may find a list of at www.galenmedical.com. Your insurance card is your proof of insurance and we cannot file or list you as having insurance without having a copy of your card. To help us process your insurance correctly and reduce timely insurance processes, please tell us of any changes in your insurance, address, phone number or place of employment.

***** IT WILL NOT BE A REQUIREMENT FOR THE FRONT OFFICE TO SEE YOUR INSURANCE CARD PRIOR TO EACH VISIT *****

Visit Co-Pays: Per your agreement with your insurance company, you are expected to pay your copayment, coinsurance, deductibles, and non-covered services at the time of your visit.

GALEN NIM'S POLICY TO COLLECT COPAY AMOUNTS PRIOR TO YOUR VISIT

Patient Information forms: We are required to furnish your insurance company with your correct name, address, insurance information and have your PICTURE and signature on file. This information must be updated completely EACH YEAR. Refusal to update forms completely may result in a canceled visit.

Confidentiality: Without your written permission, we cannot release your medical information to anyone. Please understand that we cannot discuss a case (including test results) with a spouse or relative if the patient is over the age of eighteen. If you require a copy of your medical records, we will need ten (10) working days from the time we receive your written authorization to review, copy and release your records.

Advanced Beneficiary Notices (ABN) for Medicare Patients ONLY: Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. Your provider may order certain services that they feel are necessary for good patient care, but Medicare may deny payment for that service. Therefore, you will be asked to sign an ABN. This is an agreement that you will be personally responsible for the payment in the even that Medicare denies payment.

Appointments: It is necessary that we work by appointments. Non-acute care, such as physicals and routine appointments, are usually booked within 2-4 weeks of your call, depending on your availability and the time of year.
If you are having an immediate problem, please call our office for a work-in time and you will be scheduled to see the first available provider. We will make every attempt to evaluate acute problems the same day.

Lab Visits: To avoid long waits, we do ask that you schedule appointments for your follow-up lab or Pro Time (PT- INR).

Referrals: If your insurance requires a referral to a specialist or facility for treatment, please tell your provider. If you call to request a referral, we may not be able to refer you to a specialist if we have not seen you for that particular medical problem. Only emergency referrals, as determined by a Galen Medical Provider, can be made on a same day basis.
Please allow 24 hours to contact your insurance company.
If referrals or pre-certifications are not properly obtained prior to an appointment, test or hospitalization, your insurance company may not cover the expenses.

Prescriptions: If you are taking a prescribed routine medication and need a refill, please call your pharmacy to request all refills.
Providers may ask that you be seen before a prescription is refilled; therefore, **we recommend you call several days before you have taken all of your medication**. Requests for mail in prescriptions sometimes take more time; please notify us as soon as possible. It is your responsibility as our patient to know which of your prescriptions are covered under the insurance plans you choose.
All narcotic refills are to be called into Galen NIM to be reviewed by your primary care physician. All controlled substance prescription(s) will be monitored monthly and require a signed Controlled Substance Policy that will detail the State of Tennessee requirements for all narcotics. Please allow 3 days to complete this process. Once reviewed and approved we will contact the pharmacy for you.

***** NO CONTROLLED SUBSTANCE WILL BE FILLED OVERNIGHT OR ON WEEKENDS *****

Test Results: Outpatient and lab testing require varying time limits for results to be reported to our office. Almost all tests take a minimum of forty-eight (48) hours for results to arrive at our office. Our providers review all tests, and the nurses cannot give out information until the provider has reviewed the results. We will contact you, either by mail or phone, if there are any significant abnormalities.

***** YOU MAY ALSO VIEW YOUR RESULTS AT www.mygalenmedical.com ONCE THEY HAVE BEEN REVIEWED BY YOUR PHYSICIAN *****

On Call Physician: You may reach our on-call physician by dialing our main office number, 423-870-2450.

- After regular office hours and on weekend, we have a physician on call for EMERGENCIES ONLY.
- The on-call physician cannot refill narcotics or anxiety medications.
- Routine refills are not an emergency and may not be filled after office hours or on weekends. If after hours or over the weekend you find yourself without your medication, contact your pharmacist who can supply you with enough medication to last until the office is open.

Advanced Directives: If you have either a signed Living Will or Durable Power of Attorney for Healthcare, please make sure we have a copy for your file.

Working together, we'll remain your advocates for appropriate health care in today's sometimes confusing medical environment.

David L. Adams, MD
Susan D. Bhushan, MD
Julie M. Bilbrey, MD
Julie H. Haun, MD
Ronald W. Jarl, MD
Walter D. Parkhurst, MD
Galina B. Rader, MD
James A. Stanko, MD
Ivey Williamson, MD
Sue Strother, FNP-C
Shannon Kitchings, Regional Manager

GALEN
MEDICAL GROUP

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Galen Medical Group	www.galenmedical.com
P.O. Box 1030	4976 Alpha Lane	
Chattanooga, TN 37401	Hixson, TN 37343	

To make a payment by phone and/or if you have any questions regarding your statements or our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725.**

NOTE:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____ _____

Patient Signature Date

_____

Printed Patient Name

GALEN
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4976 Alpha Lane, Hixson, TN 37343
Privacy Officer: Savannah Knuettel **E-mail:** privacy@galenmedical.com
Privacy Office: (423) 308-0280 option 8 **Medical Records:** (423) 899-4413
www.galenmedical.com

Notice of Privacy Practices

Revised effective February 11, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

We are required by federal law to give you this notice.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Galen Medical Group, P.C. will post a copy of this Notice as amended in a prominent place in our offices and on our web site.

This notice becomes effective September 1, 2013 and amends our previous form of notice. We do not deem any current amendment to constitute a material change notice. No amendment relates to any substantive right of a Galen patient or any duty of Galen. If you have any questions about the Notice of Privacy Practices, please contact our Privacy Officer at 423-308-0280 ext. option 8 or by e-mail at privacy@galenmedical.com.

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Galen Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Health Oversight Activities. We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Family Members. We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates. We have contracted with other entities to provide services to Galen Medical Group. When these "associates" require your personal health information in order to accomplish tasks asked of them by Galen Medical Group it

will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training. Your personal health information may be used for the purpose of research, teaching and/or training.

Appointment Reminders. Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation. We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illnesses. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Special circumstances requiring your authorization. Most uses and disclosures of psychotherapy notes, health information for marketing purposes, and as part of a sale of protected health information require your authorization. Galen does not maintain psychotherapy notes, nor sell your health information. Your receipt of this notice authorizes Galen to use your health information for marketing purposes. Galen does not receive financial remuneration in exchange for communicating information to you for marketing purposes.

Individual Rights

You have certain rights under the federal privacy standards.

These include:

- The right to request restrictions on the use and disclosure of your protected health information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
    - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer and will accommodate this request unless a law requires us to share that information.
- The right to receive confidential communications concerning your medical condition and treatment by alternative means or at alternative locations if you request, your request is reasonable, and you acknowledge that such alternative means or locations could risk the disclosure of all or part of your protected health information
- The right to inspect and copy your protected health information in paper or electronic format. You may obtain a form to request access to your records by contacting the medical records department at (423) 899-4413. We will provide a copy within 10 days of your request. We may charge a reasonable, cost-based fee.
- The right to amend or submit corrections to your protected health information. We may say "no" to this request, but we'll tell you in writing within 60 days.
- The right to receive an accounting of how and to whom your protected health information has been disclosed. We will include all disclosures expect for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
    - The right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for your before we take any action.
- The right to receive a printed copy of this notice, even if you have an electronic copy
    - The right to file a complaint if you feel your rights are violated. You can complain if you feel we have violated you rights by contacting the Privacy Office using the information on page 1.
        - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Galen Medical Group's Duties We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and privacy practices regarding protected health information, to notify you of a breach of any unsecured protected health information as defined by applicable regulations, and to abide by the terms of this notice then currently in effect.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit and on our website, unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Nondiscrimination Galen Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Galen Medical Group will make available language assistance services free of charge.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices. I understand Galen Medical Group, P.C. has the right to change this Notice at any time, subject to Galen's obligation to inform me of material changes.

_____ Date:_____

Signature of Patient or Legal Representative

_____ _____

Print Name of Person Signing

Relationship to Patient, *if signed by legal representative*

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization is intended to comply with the HIPAA Privacy Rule for the release, use and disclosure of medical information, and if applicable, the release, use and disclosure of medical information with respect to minors, incapacitated patients, and deceased persons. The undersigned acknowledges that Galen cannot guarantee information disclosed pursuant to this Authorization may not be re-disclosed by the recipient and/or no longer protected by privacy regulations:

The undersigned, _____.
[print name of person signing below]

[and designate one power by which the undersigned authorizes this release]:

- ☐ for Himself/Herself
- ☐ as Legal Guardian
- ☐ as Authorized Personal Representative
- ☐ as Custodial Parent
- ☐ with Health Care Power of Attorney
- ☐ as Executor of Patient's Estate
- ☐ as Spouse of Deceased Patient [only if no other known authority listed above]

hereby authorizes Galen Medical Group, P.C. ("Galen") to disclose the medical record for:

_____, born _____
[*print name of patient*] [*date of birth*]

To:_____ [*party to whom records will be released*]	From:_____ [*party releasing records*]
Address:_____ _____	Address:_____ _____
Phone: _____ [*required only for fax or secure email verification*] Fax:_____	Phone:_____ Fax:_____
E-mail: _____ [only *for verification and encrypted records*]	E-mail:_____

by the following means [choose one]:

- ☐ mail
- ☐ fax
- ☐ pick up in person

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Information to be Released

- ☐ Entire Medical Record
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-Ray
- ☐ Clinic Visits
- ☐ ER Records
- ☐ Discharge Summary
- ☐ EKG
- ☐ Laboratory
- ☐ Physician Orders
- ☐ Other: _____

Purpose of Release

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of Care
- ☐ Worker's Compensation
- ☐ Disability
- ☐ Insurance
- ☐ Disposition
- ☐ Billing

by the following means [choose one]:

☐ mail ☐ fax

☐ pick up in person

GALEN HAS NOT DETERMINED WHETHER OR NOT INFORMATION CONCERNING THE DIAGNOSIS OR TREATMENT OF SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV OR AIDS, MENTAL HEALTH, AND/OR THE USE OF ALCOHOL, DRUGS, OR TOBACCO MAY BE PRESENT IN THIS MEDICAL RECORD. IF SUCH INFORMATION MAY BE PRESENT IN THE MEDICAL RECORD, THE UNDERSIGNED AUTHORIZES THE RELEASE OF SUCH INFORMATION.

☐

Initials Required for this Authorization to be effective for any portion of the Medical Record

The undersigned acknowledges that any prior agreements to restrict protected health information ("PHI") do not apply to this authorization and that Galen is hereby authorized to release and disclose the patient's entire medical record without restriction, except as set forth in this authorization.

The undersigned further understands that:

- -The undersigned is not required to sign this authorization for treatment, payment, enrollment, or eligibility for benefits.
- -This authorization is effective for one year, but may be revoked in writing at any time, except for any actions Galen may have already taken at the time of the revocation.
- -If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.

_____ _____

signature of patient or patient representative pursuant to the designated authority above [date signed]

accepted and verified by _____ on _____

[Galen Representative] [*date*]

I understand and agree that Galen is relying on my status as the personal representative of the patient. Under penalties of perjury, I hereby certify that to the best of my information and belief I am a personal representative.

Ver. 2017-01

Galen Medical Group
4980 Alpha Lane Hixson, Tn. 37343

Patient Name: _____

We are happy that you have chosen us to provide your medical care. Please complete the following questionnaire to allow us to become as knowledgeable as possible about your history.
Please bring this form with you, **DO NOT MAIL BACK.**

MAIN REASON FOR OFFICE VISIT: _____

REVIEW OF SYSTEMS

GENERAL:

	YES	NO
change in energy level		
problem with sleep		
problem with concentration		
weight loss or gain		

NEURO:

history of passing out spells		
history of seizures or strokes		
weakness or numbness in in arm / leg		
frequent severe headaches		

ENT:

recent onset of hearing loss or hoarseness		
seasonal allergy problems		

CARDIAC:

chest pain with exertion		
irregular or racing heartbeat		
history of cardiac disease		
last EKG (heart tracing) Date - Normal ?		

PULMONARY:

shortness of breath		
chronic cough or wheezing		
history of lung disease		
last chest X-Ray Date - Normal ?		

GASTROINTESTINAL:

frequent indigestion		
problem swallowing		
upper stomach pain		
crampy abdominal pain		
recent change in bowels		
constipation or diarrhea		
blood in stool or black stool		
history of : ulcers / hiatal hernia		
gallbladder disease		
colon / bowel disease		
Colonoscopy / Stool Cards Date - Normal ?		

MUSCULOSKELETAL:

frequent leg cramps or muscle pain		
arthritis in joints		
swelling in ankles		
stiffness in the morning		

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FEMALE:

	YES	NO
frequent vaginal discharge		
still having regular periods?		
DATE of your last period		
could you be pregnant now?		
severe premenstrual symptoms		
breast pains, discharge, or lump		
DATE of last Mammogram Normal ?		
DATE of last Pap Smear Normal ?		
number of pregnancies ( )		
History of disease of the female organs		
loss of bladder control		
frequent (> 2-3) nighttime urination		

MALE:

trouble passing urine		
loss of sexual ability		
history of kidney stones		
history of disease of male organs		

PAST MEDICAL HISTORY:

Allergies to medicines: _____

Current Medications: _____

_____

PREVIOUS MEDICAL PROBLEMS (CIRCLE)

Diabetes Hypertension Thyroid Disease Heart or Lung Problems

DIABETIC EYE EXAM : _____**Yes (DATE**_____**)** _____**No**

HOSPITALIZATIONS, OPERATIONS OR SURGICAL PROCEDURES AND DATES

_____

_____

ANY OTHER PHYSICIANS YOU SEE:

_____

IMMUNIZATIONS AND DATES: TETANUS _____ FLU _____ PNEUMOVAX _____

Prevnar 13 _____ HEPATITIS A _____ HEPATITIS B _____

FAMILY HISTORY (for immediate family / grandparents / aunts / uncles)

Colon / Breast / Prostate / other Cancer _____

Thyroid Disease_____ Diabetes _____

Heart attack or bypass surgery before age 65_____

SOCIAL HISTORY: Your occupation _____

Tobacco use _____ daily amount _____

Alcohol use _____ daily amount _____

Daily seat belt use: (Circle) Yes No

DO YOU HAVE A LIVING WILL ? _____ **(IF YES, PLEASE PROVIDE US WITH A COPY).**

Completed by:_____ Date: _____

REVIEWED BY: _____**DATE(S)**_____