Tri Cities Health PC

PATIENT REGISTRATION FORM

TODAYS DATE:_____

PATIENT'S LAST NAME:_____**FIRST:**_____**MIDDLE:**_____

DATE OF BIRTH:_____ **AGE:**____ **GENDER: MALE/FEMALE/OTHER**

CURRENT ADDRESS:_____

PHONE:_____ **OK TO RECEIVE TEXT APPT REMINDERS? YES/NO**

EMAIL ADDRESS:_____

OCCUPATION:_____ **EMPLOYER:**_____

IN THE EVENT OF AN EMERGENCY, WHO WOULD YOU WANT US TO CONTACT?

NAME/NUMBER/RELATIONSHIP:_____

HOW DID YOU HEAR ABOUT US? _____

OTHER FAMILY MEMBERS SEEN HERE:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be utilized by Lab Corp, Quest, Boston Heart Diagnostics. I understand that I am financially responsible for any balance. I authorize TCH or insurance company to release any information required to process my claims. This registration will remain valid indefinitely unless repealed in writing by patient.

_____ _____

Patient Signature **Date**

PRIVACY PRACTICES/PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (2 pages) for Tri Cities Health PC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care/Patient Registration) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Printed Patient Name

REVIEW OF SYSTEMS

NAME:_____ DOB:_____ DATE:_____

*PLEASE MARK IF YOU HAVE HAD ANY OF THESE SYMPTOMS IN THE LAST MONTH

NEUROLOGICAL/EENT

__MIGRAINES __SLURRED SPEECH

__HEADACHES __RINGING EARS

__ALTERED TASTE/SMELL

__NIGHT BLINDNESS __SORE THROAT

__GINGIVITIS __NOSE BLEEDS

__EAR PAIN

CARDIOVASCULAR

__CHEST PAIN __RACING HEART

__UNUSUAL BEATS __ANEMIA

__SWOLLEN HANDS/FEET/EYES

__DECREASED EXERCISE ENDURANCE

RESPIRATORY

__RECURRENT RESP INFECTIONS

__ASTHMA __CHEST CONGESTION

__WHEEZING __SNEEZING

GASTRO-INTESTINAL

__STOMACH PAIN __CRAMPS

__CONSTIPATION __NAUSEA

__VOMITING __DIARRHEA

__BLOATING __HEARTBURN

MUSCULOSKELETAL

__JOINT PAIN __ARTHRITIS __TICK BITE

__CHRONIC PAINS __MUSCLE ACHES

__MUSCLE SPASMS __TICK BITES

SKIN

__ECZEMA __DERMATITIS __RASHES

__EXCESS SWEATING __BRITTLE NAILS

__HAIR LOSS __EASY BRUISING __SKIN TAGS

__UNUSUAL MOLES OR FRECKLES

__INCREASED BLEEDING __NUMBNESS

__DIABETIC ULCERS

GENITOURINARY

__UTERINE FIBROIDS __OVARIAN CYSTS

__CANCER
(BREAST/OVARY/PROSTATE/OTHER)

__PROSTATE PROBLEMS __HERPES
__ABNORMAL PAP SMEAR

EMOTIONAL/MENTAL/ENERGY

__DEPRESSION __ANXIETY

__MOOD SWINGS __IRRITABILITY

__SUICIDAL THOUGHTS __CONFUSION

__MEMORY LOSS

__FATIGUE __HYPERACTIVITY __STRESS

__RESTLESSNESS __INSOMNIA __SNORES

__DAYTIME SOMNOLENCE __LOW SEX DRIVE

WEIGHT

__DECREASED APPETITE __WT LOSS

__INCREASED APPETITE __WT GAIN

__FOOD CRAVING __BINGE EATING

__UNABLE TO LOSE WEIGHT

HEALTH HISTORY

NAME/DOB:_____

OTHER PHYSICIANS SEEN/CLINIC:_____

Please CIRCLE if you are CURRENTLY having any of the following conditions or have had them in the PAST: AIDS/HIV ALCOHOLISM ANEMIA ANOREXIA APPENDICITIS ARTHRITIS ASTHMA BLEEDING DISORDERS BREAST LUMPS BRONCHITIS BULEMIA CANCER CATARACTS CHEMICAL/DRUG DEPENDENCY CHICKEN POX DIABETES EMPHYSEMA EPILEPSY FRACTURES GLAUCOMA GOITER GONORRHEA GOUT HEART DISEASE HEPATITIS HERNIA HERNIATED DISC HERPES HIGH CHOLESTEROL KIDNEY DISEASE LIVER DISEASE MEASLES MIGRAINES MISCARRIAGE MONONUCLEOSIS MULTIPLE SCLEROSIS MUMPS OSTEOPOROSIS PACEMAKER PINCHED NERVES PNEUMONIA POLIO PROSTATE PROBLEMS PROSTHESIS PSYCHIATRIC CARE RHEUMATIC FEVER RHEUMATOID ARTHRITIS SCARLET FEVER STROKE/TIA SUICIDE ATTEMPT THYROID PROBLEMS TONSILLITIS TUBERCULOSIS TUMORS/GROWTHS TYPHOID FEVER ULCERS VAGINAL INFECTIONS VENEREAL DISEASE WHOOPING COUGH BLOOD TRANSFUSIONS OTHER:_____

Do you currently have a health care provider? _____ Who?_____

List any PRESCRIPTION and OTC medications (dose and frequency) that you currently take:_____

_____

_____

List any prior surgeries and hospitalizations (type and date):

_____

List any allergies:_____

List any vitamins/herbs/supplements:_____

Is there a family history (mother, father, or brothers/sisters) of the following?

Heart Disease_____ Diabetes_____Cancer_____
Arthritis_____ Obesity_____ Blood Disorders_____

Do you exercise (circle)? Never Daily Weekly Type: Walk Run Swim Gym

Do your work activities mostly involve: Sitting Standing Light Labor Hard Labor

What is your daily/weekly intake of the following?

Caffeine ___cups/day Alcohol __drinks/wk of _____ (type) Cigarettes ___packs/day # yrs___

Smokeless tobacco__cans/bags per day # yrs ___

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Signature Date

TRI CITIES HEALTH HIPAA AUTHORIZATION FORM FOR FAMILY/FRIENDS

I, _____(NAME) _____(DOB), give permission to all my healthcare and medical services providers and payers to disclose and release my protected health information described below to:

Name(s) and Relationship: (May put "No one" if you do not wish us to release any information)

_____

_____

Healthcare information to be disclosed: (check all that apply)

( ) My complete health care record (including but not limited to diagnoses, lab results, prognosis, treatment, billing, for all conditions) OR

( ) My complete health care record, as above, with the exception of the following information:

( ) Mental health records ( ) Communicable diseases (including HIV/AIDS)

( ) Alcohol/drug abuse treatment ( ) Other: please specify_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization is effective until ( ) _____ OR ( ) All past, present, future time periods.

*You may revoke this authorization at any time by notifying your health care provider in writing.

_____

Printed Name of the individual giving this authorization Date

_____

Signature of the individual giving this authorization Relationship to patient

Authorization to Release Healthcare Information

Tri Cities Health PC

Dr. Kimberly McMurtrey FNP-C, DNP

2208 W Elk Ave

Elizabethton TN 37658

Phone: 423-543-7000

Fax: 423-543-7002

*Hours: Tues, Wed, Thursday 8:30-4:30pm

Patient Name:_____DOB_____

___ I request and authorize_____ to release healthcare information of the above named patient to Tri Cities Health PC.

___I request and authorize Tri Cities Health to release specified healthcare information to _____.

This request and authorization applies to:

___Healthcare information re:_____

___All healthcare information.

___YES___NO I authorize the release of my STD, HIV/AIDS testing, whether positive or negative, to the persons listed above. I understand that the persons listed above will be notified that I must give specific written permission before the disclosure of test results to anyone.

___YES___NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the persons listed above.

Note: Sexually transmitted Disease as defined by law , RCW 70.24 et seq. includes herpes, herpes simplex, human papilloma virus, genital wart, condyloma, nonspecific urethritis,syphilis, VDRL, chancroid, LGV, HIV, AIDS, and gonorrhea.

Patient Signature/Date_____