HMG
HOLSTON MEDICAL GROUP

Welcome to our office

Where did you hear about us?
☐ Yellow Pages (YP) ☐ Newspaper (NP) ☐ Website (WS)
☐ Friend or Family (FF) ☐ Physician Referral (PR)
☐ Other (OT) _____

OFFICE USE ONLY
Physician:_____
Approved by:_____
Date:_____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name_____ (First / Middle / Last)
Address_____
City_____ State_____ Country _____ Zip_____ Phone # (____) _____
Birthdate_____ Sex M or F Race_____ Marital Status S M W D
Emergency Phone #: (____) _____ Cell Phone # (____) _____
Social Security #_____ Employer_____
Address of Employer_____ Work Phone #_____
May we contact you at work? Y N By E-Mail Y N E-Mail Address _____
Emergency Contact Name_____ Emerg. Phone # (____) _____
Relationship to billing party_____

Guarantor/Responsible Party

Name_____ (First / Middle / Last)
Address_____
City_____ State_____ Zip_____ Phone #_____
Birthdate_____ Sex M or F Marital Status S M W D
Social Security #_____ Driver's License #_____
Place of employment_____ Work Phone #_____

OTHER INFORMATION

Name and address of nearest relative not living with you_____
Address_____ City_____ State_____ Zip_____ Phone #_____

If you are currently under another physician's care, please list:

Name_____
Address_____ City_____ State_____ Zip_____

Whom may we thank for referring you to us?_____

INSURANCE

1. Primary Insurance Company Name_____
Group #_____ Policy Member #_____
Subscriber Name_____ Subscriber Birthdate_____ Sex M or F Social Security #_____
Subscriber Employer and Address_____

2. Secondary/Supplemental Insurance Name_____
Group #_____ Policy/Member #_____
Subscriber Name_____ Subscriber Birthdate_____ Sex M or F Social Security #_____
Subscriber Employer and Address_____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date_____ Signature_____

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Holston Medical Group Otolaryngology
Medical History

Date: _____
MRN: _____

Referring Physician: _____

Name: _____ **DOB** _____ **Age** _____

Phone (home): _____ **Work/ Cell:** _____

Primary reason for coming to see us? _____

_____

Medications: _____

_____

Allergies to medications: _____

Habits

Do you now use or have you ever used tobacco? Yes_____ No_____
If you use/used tobacco, which form? _____
If you quit, when? _____
Do you drink alcohol? Yes_____ No_____

Medical conditions/surgical history_____
_____

Family History

- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Cancer
- ☐ Hearing loss
- ☐ Tuberculosis
- ☐ Immune Disease

Other:

_____
_____
_____

Systems Review

General:
- ☐ Weight loss
- ☐ Fever
- ☐ Chills

Head and Neck:
- ☐ Headache
- ☐ Ringing in the ears
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Nosebleeds
- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Hoarseness

Eyes:
- ☐ Vision Changes
- ☐ Seeing Double
- ☐ Glasses

Endocrine:
- ☐ Temperature Intolerance
- ☐ Dry skin
- ☐ Weight gain

Cardiovascular:
- ☐ Chest pain
- ☐ Murmur
- ☐ Leg pain

Gastrointestinal:
- ☐ Nausea
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation

Urogenital:
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Urinary stream is smaller

Neurologic:
- ☐ Fainting
- ☐ Unsteadiness
- ☐ Falls

Psychological:
- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression

Musculoskeletal:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Limb pain

Skin:
- ☐ Skin discoloration
- ☐ Rash
- ☐ Sores

Hematologic:
- ☐ Easy bruising
- ☐ Anemia
- ☐ Easy bleeding

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Seasons

MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Patient Signature (if applicable) | Date

_____ _____

Authorized Representative Signature | Relationship to Patient

---

I understand that my Protected Health Information (PHI) will only be <u>verbally</u> communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

_____ _____

Employee Signature | Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

نبيه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، فيرجى طلب التحدث مع مدير المكتب

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Parental Pre-Authorization for Minors

It is the policy of Holston Medical Group to comply with state and federal laws that govern the treatment of children under the age of 18. Under this law, it is necessary to have the presence of a parent or legal guardian or a signed document giving consent before evaluation and/or treatment can be rendered to children under the age of 18.

I (we) request and authorize Holston Medical Group and its personnel to provide medical care to my child:

Child's Name_____ Date of Birth_____

List any individuals other than the legal guardians to whom you give permission to bring your child in for medical treatment during your absence.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Note: If there is any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no-parent, etc.) Please explain in the space below with your signature, printed name and phone number at which you may be reached. A copy of the legal document will need to be obtained.

_____

_____

_____

_____

Legal Guardian/Parent's Signature_____

Printed Name_____ Phone_____

Witness_____ Date_____

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FINANCIAL POLICY

MRN#: _____

Date Received: _____

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

Date	Signature	Printed Name

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MRN: _____

Date: _____

Communicating with Your Specialist

Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, Follow my Health. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your provider's telephone message will direct you on how to contact the HMG Physician on Call.

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Monthly refills of any controlled medications (pain medication, anxiety, etc.) will only be given during an office visit within regular business hours. Sample medication will only be distributed during normal business hours.

Printed Name: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

HMG HOLSTON MEDICAL GROUP
Multi-Specialty Physician Practice
105 West Stone Drive • Suite 4-D • Kingsport, TN 37660 • Telephone (423) 392-6299 • Facsimile (423) 392-6920
Otolaryngology

Dizziness Questionnaire

Name_____ Date_____

Check the following that apply to the description of your dizziness.

- ❒ Lightheadedness
- ❒ Faint feeling
- ❒ Swimming sensation in head
- ❒ Room/objects spinning around you
- ❒ Feeling like your floating
- ❒ Unstable horizon
- ❒ Blackouts
- ❒ Imbalance

Occurs while

- ❒ Standing up
- ❒ Walking
- ❒ Turning
- ❒ Rolling over in bed

Check the following that associate with your dizziness.

- ❒ Nausea
- ❒ Vomiting
- ❒ Pressure in head
- ❒ Pressure in ear: (Left / Right / Both)
- ❒ Change in hearing: (Left / Right / Both) Describe_____
- ❒ Ringing in ear: (Left / Right / Both)
- ❒ Headaches
- ❒ Numbness : Where_____
- ❒ Weakness: Where_____
- ❒ Slurred speech

Describe your first experience of dizziness.

Date:_____

What were you doing when it started_____

How long did it last_____

Since the first event the dizziness

- ❒ Is constant
- ❒ Comes in attacks
  - ❒ Same as first
  - How frequent_____

Do you have

- ❒ History of Migraine Headaches (self or family members)
- ❒ An autoimmune disease
- ❒ Skin Rashes
- ❒ Arthritis (extremities/back/neck)
- ❒ History of a whiplash injury
- ❒ Motion intolerance
- ❒ Trouble walking