

Solutions Medical Centers

851 West Elk Avenue Elizabethton, TN 37643

Patient Name _____ Date: _____

Email: _____

SS #/SIN _____ DOB _____ Male Female

Home phone _____ Cell Phone _____

Check appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's Address _____

City _____ State _____ Zip _____

Employer Name _____

Spouse or Patient's Guardian name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____

Phone _____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent or Guardian

Date

Responsible Party

Name of The Person responsible for this account _____

Relationship to Patient _____

Address _____

Home Phone _____ Cell Phone _____

E-Mail _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? Yes No

Do you have any Medical insurance? Yes No if yes, complete the following:

Name of the insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____

Name of Employer _____ Work Phone _____

Address of Employer _____ State _____ Zip _____

Insurance Company _____ Group # _____

Union or local # _____

Ins. Co. Address _____ City _____

State _____ Zip _____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Solutions Medical Centers** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X _____
(patient signature)

X _____
(signature of Guardian if applicable)

X _____
(please print patient name)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint:

History of Present illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration:** _____
(How severe is the pain/problem on a scale of 1-10 with 10 (How long have you had this pain/ problem?
Being the most severe?) When did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this
Pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors** _____
(What other associated problems have you been having?) (What makes the pain/problem worse or better?
Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES
Whooping Cough...	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray	_____	
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES
Rheumatic Fever...	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES
Venereal Disease...	NO	YES	Blood or Plasma			Mitral Valve Prolepses....	NO	YES
			Transfusion.....	NO	YES	Stroke.....	NO	YES

Hepatitis.....NO YES
 Ulcer.....NO YES
 Kidney Disease.....NO YES
 Thyroid Disease.....NO YES
 Bleeding Tendency.....NO YES
 Any other Disease.....NO YES
 (Please List):

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____

Patient Social History:
Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure
At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____
Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

PATIENT NAME: _____ **DATE:** _____

Name: _____ DOB: _____ Date: _____

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
 1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date