Maltman Medical Center Health Information Questionnaire

Name _____ Date Of Birth _____

Male ☐ Female ☐ Marital Status other

Social Security # _____ Phone # _____

Address _____

E-Mail _____ (to access Patient Portal)

Primary Insurance

Insurance _____

Member ID _____

Group # _____

Name of Subscriber _____

Relationship to Patient _____

Subscriber DOB _____

Subscriber SSN _____

Secondary Insurance

Insurance _____

Member ID _____

Group # _____

Name of Subscriber _____

Relationship to Patient _____

Subscriber DOB _____

Subscriber SSN _____

It is OK to contact me via: ☐ Phone for appt reminders ☐ Text Message
☐ Email for appt reminders

Preferred Pharmacy Name: _____

Location/Phone # _____

Emergency Contact: _____ Phone # _____

What is the Reason for Visit Today? _____

How did you hear about our clinic? (circle all that apply)

Family/Friend Facebook Twitter Google Radio TV Flyer Sign

Referral from another Provider _____

Festival _____ Other _____

Maltman Medical Center

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Maltman Medical Center (MMC), through it's individual physicians, providers, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician/provider and provided by Maltman Medical Center.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the provider/physician or Maltman Medical Center.

I acknowledge that I have received a copy of Maltman Medical Center's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.maltmanmedical.com. I consent to be called on my cell phone/home phone concerning healthcare services rendered to me, messages may be left on my voice mail, and receiving email or postal mail related to healthcare services.

To protect against the transmission of blood borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test by blood for certain diseases while I am a patient at Maltman Medical Center. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my provider/physician and that the results of all test will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient Name Patient Signature

_____ _____

Witness Date

Patient, _____ is a minor, or is unable to sign.

_____ _____

Person Giving Consent Relationship to Patient

_____ _____

Witness Date

Maltman Medical Center
Consent & Financial Responsibility

This consent is required by the Health Insurance Portability and Accountability Act of 1995 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed. If such restriction is requested, it must be done in writing.

Consent for Care

I, with my signature, authorize the providers of MMC, and any employee working under the direction of the Nurse Practitioner/Physician/PA to provide medical care for me, or to this patient for which I am the legal guardian or representative. This medical care may include services and supplies related to my health (or the identified person) and may include, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received. I understand that I am responsible for all co-payments, amounts applied to deductibles, co-insurance, and other amounts that may be deemed my responsibility by the payment sources; as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment I am expected to make payment when checking in for my appointment.

I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. Maltman Medical Center is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving services. For example, not all health plans cover health screenings as a benefit. If I seek care outside the contract terms of my plan, I am aware that I will be responsible for all charges that are incurred.

Maltman Medical Center is a Nurse Practitioner owned and operated facility.

Thank you for your understanding and cooperation with this policy. It is our privilege to provider your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above. I have received and read the Privacy Notice (HIPAA) and agree to the terms.

_____

Patient/Responsible Party Date

Previous Primary Care Provider _____

Location/Phone # _____

Last seen _____ Last Physical _____ Last Labs _____

Medication ALLERGIES & Reaction _____

_____

_____

What Medications are you CURRENTLY taking? (attach list if necessary)

Medication	**Dose**	**Times per Day**	**Prescribed By**	**Do You need a refill today?**

VACCINE History (provide approx.. date given)

Influenza (Flu) _____ Tetanus _____

Pneumonia _____ Shingles _____

Please check any symptoms (PROBLEMS) below that you are **currently experiencing:**

Constitutional
- ☐ Fever/Chills
- ☐ Feeling poorly
- ☐ Feeling Tired
- ☐ Recent weight gain/loss
- ☐ Night Sweats

EYES
- ☐ eye pain
- ☐ Red eyes/Discharge
- ☐ Vision Changes
- ☐ Dry eyes
- ☐ Itchy eyes

ENT
- ☐ Earache
- ☐ Sore Throat
- ☐ Nasal congestion/discharge
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Hearing loss

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heart beats
- ☐ Lower extremity edema
- ☐ Leg cramps
- ☐ Pain with exercise
- ☐ Slow heart rate
- ☐ Fast heart rate

Respiratory
- ☐ Shortness of breath
- ☐ Shortness of breath during exertion
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath lying down or at night

Gastrointestinal
- ☐ Nausea and/or vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Trouble swallowing

Endocrine
- ☐ Excessive thirst/urination
- ☐ Drooping of eyelid
- ☐ Hot or Cold Intolerance
- ☐ Hair loss
- ☐ Generalized weakness

Genitourinary
- ☐ Dark or bloody stool
- ☐ Pain with urination
- ☐ Frequency/urgency of urination
- ☐ Night time urination
- ☐ Hesitancy
- ☐ Incontinence (loss of urine/stool)
- ☐ Blood in urine
- ☐ Genital lesion
- ☐ Difficulty with menstrual periods
- ☐ Erectile dysfunction

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Limb pain/swelling
- ☐ Muscle cramps/weakness

Integumentary
- ☐ Skin rash
- ☐ Itching
- ☐ Skin lesions
- ☐ Change in mole/lesion
- ☐ Breast lump/pain

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Mental changes
- ☐ Fainting
- ☐ Limb weakness
- ☐ Difficulty walking
- ☐ Numbness
- ☐ Tremor
- ☐ Radiating pain

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal/homicidal thoughts
- ☐ Personality changes/irritability
- ☐ Sleep disturbances

Blood/Lymph
- ☐ Easily bruising/bleeding
- ☐ Swollen glands

FAMILY History Have any members of your immediate family (**Parents, Siblings, Grandparents, Children**) ever had: (List Family Member)

Breast Cancer _____
Colon Cancer _____
Other Cancers _____
Thyroid Disease _____
Hypertension (high blood pressure) _____
Stroke _____
Heart Problems _____
Diabetes _____

SOCIAL HISTORY Circle Answer

Able to care for self Yes
Live alone or with others Wth Others
Advance Directive Yes
Are you currently employed? Yes
Occupation _____
General stress level? High
Number of Children _____
Alcohol intake High
Caffeine intake High
Illicit Drugs? Yes
List Drugs _____
_____
Exercise level High
Diet Low Sugar

Hard of Hearing/deaf one/both ears Yes
Legally Blind Yes
Sexually active? Yes
Protected Sex? Yes
Smoking status Yes
Smoking how much? _____
Has smoked since age _____
Passive smoke exposure? Yes
Chewing Tobacco? Yes
Tobacco years of use _____

GYNECOLOGICAL History

Last PAP _____
Any Abnormal PAP Yes
OBGYN MD _____
Had HPV Vaccine? Yes
Sexually Active? Yes
Change in partner in last 6 mths? Yes
History of STI/STD's Yes
Age at first child birth _____
Current birth control method
_____
Desired Birth Control Method
_____
Last Menstrual Period
_____
Date of last Mammogram
_____
Total Births _____
Premature _____
Miscarriage _____
Full Term _____
Ectopic _____

Hysterectomy Full
Ovaries Remaining Right
Approx. Year _____

SURGICAL History

_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Place a check on those that apply.

ADD/ADHD ☐
AIDS/HIV ☐
Abuse/Domestic Violence ☐
Acid Reflux (GERD) ☐
Acne ☐
Allergies (Food, Seasonal, Environment) ☐ _____
Allergies/Hayfever ☐
Anemia ☐
Anesthesia Complications ☐
Anxiety Disorder ☐
Arthritis ☐
Asthma ☐
Autism Spectrum Disorder(ASD) ☐
Autoimmune Disease ☐
Bedwetting ☐
Birth Defects or Inherited Disease ☐
Bladder/Kidney Problems ☐
Blood Diseases ☐
Blood Transfusion ☐
Breast Cancer ☐
Breast Problem ☐
COPD ☐
Cancer ☐
Cervical Cancer ☐
Chicken Pox ☐
Chronic Ear Infections ☐
Congestive Heart Failure ☐
Constipation ☐
Coronary Artery Disease ☐
Depression ☐
Depression/Postpartum ☐
Dermatologic Disorders ☐
Developmental or Behavioral Disorders ☐
Diabetes ☐
Difficulty Swallowing ☐
Diverticulitis ☐
Drug/Latex Allergies ☐
Ear or Hearing Problems ☐
Eating Disorder ☐
Eczema ☐
Endometriosis ☐
Fibromyalgia ☐
GI Problems ☐
Gestational Diabetes ☐
Gout ☐
Headaches ☐
Heart Disease ☐
Heart Problems ☐
Hematologic Disorders ☐
Hepatitis ☐
Hepatitis/Liver Disease ☐
High Cholesterol ☐
History of STI/STD ☐
History of Abnormal PAP ☐
Hospitalizations _____
Hypertension ☐
Hyperthyroidism ☐
Hypothyroidism ☐
Infertility ☐
IV Drug Use ☐
Kidney Stones ☐
Kidney Disease ☐
Liver Disease ☐
Lung Disease ☐
MRSA Exposure ☐
Meniere's Disease ☐
Mental Disorder ☐
Muscle, Joint, Bone Problems ☐
Neurologic/Epilepsy ☐
Osteopenia ☐
Osteoporosis ☐
Ovarian Cancer ☐
Polycystic Ovaries ☐
Pre-Eclampsia ☐
Pulmonary (TB, Asthma) ☐
Reflux/GERD ☐
Seizures/Epilepsy ☐
Skin Problems ☐
Stroke ☐
Thrombophilias ☐
Trauma/Violence ☐
Tuberculosis ☐
Varicosities ☐
Vision/Eye Problems ☐

List ANY and ALL SPECIALISTS You Have Seen or Currently See

Provider Name	Specialty	Location	Phone Number

Dentist Name _____ Last Seen _____

Date of Last Colonoscopy? _____
Any abnormalities or polyps? _____

If **DIABETIC** Last Foot Exam _____
Last Eye Exam _____

Are you currently seen by a Pain Management Specialist? Yes/No
Name of MD _____

MALE PATIENTS
History of Testicular Cancer? Family
History of Prostate Cancer? Family

Office Policies

_____ If you are 15 mins late for your appointment, we ask that you reschedule. This is a courtesy to our patients and providers.

_____ There will be a $25 fee for **"No Show's" & Cancellations** that occur less than 24 hours prior to your appointment time. Insurance does NOT COVER this cost, it is an out of pocket expense.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call **at least 24 hours in advance to cancel or reschedule your appointment.**

If for any reason you need to cancel an appointment, please notify our office as soon as possible.

After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

_____ As a courtesy to all of our patients and providers, we ask that you be 15 mins early for your appointment to allow for check-in and paperwork.

_____ **Refill Requests**: Allow 48 hours for refill requests to be filled. DO NOT wait until you are out of a medication to request a refill.

_____ Refills & Appointment Requests will NOT be granted via the On-Call phone.

_____ If your **Deductible has not been met**, $100 PLUS your Co-Pay is due prior to seeing the Provider. This money will go toward your deductible and if there is an outstanding balance above this, you will receive a paper bill for the balance via the mail.

_____ **Co-Pays & Outstanding Balances** are due PRIOR to seeing the Provider.

Patient Name: _____

Signature: _____

Date: _____

Authorization For Disclosure of Medical Information

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

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

_____

Covering the period (s) of health care:

From Date: _____ To Date: _____

Information to be disclosed:

____ Complete Health Record

OR ONLY THE FOLLOWING:

_____ History & Physical _____ Progress Notes _____ Billing/Financial

_____ Labs/Imaging _____ Consult Reports _____ Other _____

From the following medical offices/providers:

_____ Maltman Medical Center
9051 Executive Park Dr.
Suite 202
Knoxville, TN 37923
865-337-7793
865-240-3539 Fax

_____ Victory Treatment Program
9051 Executive Park Dr.
Suite 202
Knoxville. TN 37923
865-337-7812
865-240-3539 Fax

For the purposes of Continuing patient care.

X At the request of the patient.

I understand I have the right to refuse to sign this form and that my refusal will not result in the medical provider(s) limiting or not providing healthcare to me with the following exceptions: 1. Refusal to sign this authorization if it is for disclosure of information created for research that includes treatment, may result in the medical provider declining to provide the research-related treatment. 2. Refusal to sign this authorization, if its 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. I also understand this authorization will expire one year from the date it is signed. I further understand that I may revoke in writing at any time.

I understand by signing below that I am giving specific consent to release information related to testing and treatment for HIV, AIDS, mental/psychiatric care, or alcohol/drug abuse if such is contained in the medical record.

Patient Signature: _____ Date: _____

Witness _____ Date: _____