Heritage Medical Associates

DEMOGRAPHICS SHEET

Name _____ Birthdate _____

SSN _____ Sex _____ Employer _____

Patient Contact Information

Address _____ City _____

State _____ Zip _____ Home _____

Work _____ Cell _____ Email _____

PCP _____ Referring Dr. _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Employment Status: □ Full Time □ Part Time □ Not Employed □ Self Employed

□ Retired □ Military

Student Status: □ Full Time □ Part Time □ Not a Student

Parent / Guardian Contact Information (Patients under 18)

Name _____ Relationship to Patient _____

Date of Birth _____ SSN _____

Parent / Guardian Contact Information (Patients under 18)

Name _____ Relationship to Patient _____

Date of Birth _____ SSN _____

Emergency Contact Information

Name _____ Relationship to Patient _____

Home _____ Work _____ Cell _____

Appointment Reminder Preference: □ Call □ Text □ Email

Please select one of the following:

Race: □ Asian □ Native Hawaiian □ Other Pacific Islander □ African American

□ Native American □ White □ More than One Race □ Declined to Answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Declined to Answer

Preferred Language: □ English □ Spanish □ Other

Insurance and Fees: Heritage Medical Associates participates in most insurance networks including:

- Aetna
- BlueCross BlueShield of TN
- BCBS BlueCard PPO
- Blue Grass Family Center Care
- Cigna / Great West
- First Health
- Humana Choice Care
- Multi Plan/PHCS
- NovaNet PPO
- PPO USA-GEHA
- Prime Health Services
- Traditional Medicare
- Tricare Standard / Reserve
- United Healthcare

And the following Medicare Advantage Plans:

- Cigna-HealthSpring
- BlueCross BlueShield BlueAdvantage

Please provide your current insurance information when you schedule your appointment and bring proof of your insurance with each visit. If you have any questions about our insurance participation, charges, or your bill, please call our billing office at 615-284-3880.

Collection of Co-Payments and Payments of your Bill: Payment of all known deductibles, co-payments, coinsurance, outstanding balances and non-covered services will be required at the time service is rendered. Patients who do not have proof of insurance will be responsible for full payment at the time of service.

For out-of-network patients, we require full payment at the time of the service but we will file your insurance claims for reimbursement on your behalf as a courtesy.

Patients with High Deductible Insurance plans, including BlueCross BlueShield Network E, P, and S, Humana PPOx and Cigna Local Plus through the exchanges, whose benefits have been verified and have not met their deductible, will be required to make a payment of ***no less than $100*** towards the services rendered at each non-preventive care visit.

If during the course of a preventive exam, services related to a new or chronic condition are completed, your insurance company may apply a copay to the visit. You will be responsible for this copay and any corresponding charges.

Payment Options for Payments: We accept Cash, Check, Visa, MasterCard, Discover and American Express. There is a $25.00 returned check fee for all checks returned for insufficient funds. Post-dated checks will not be accepted.

Past Due Balances: We require that past due balances be paid, in full, prior to a subsequent office visit. Outstanding balances may result in dismissal from the practice. If you are unable to make payment, please contact our Business Office at 615-953-4105. In the event an account is placed with a collection agency, you will be responsible for the 30% collection fee, court costs and legal fees.

Missed Appointment Policy: Should you need to cancel or reschedule your appointment we ask that you advise us a minimum of 24 hours in advance of your scheduled appointment. Failure to notify the office could result in a minimum charge of $25.00 to your account. Multiple missed appointments may result in dismissal from the practice. If you arrive late you may be asked to reschedule your appointment.

Filing of Your Insurance: I hereby authorize my insurance benefits to be paid directly to Heritage Medical Associates, realizing I am responsible to pay non-covered services and deductibles and copayments. I hereby authorize the release of pertinent medical information to insurance carriers.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Patient Name (Print) _____ Date _____

Patient/Representative Signature _____ Relationship to Patient _____

Heritage Medical Associates

PRIVACY NOTATION / CONSENT OF DISCLOSURE

PATIENT ACKNOWLEDGEMENT FORM

The following information will be used to contact the patient, parent or legal guardian, in regard to protected health information (i.e, test results, referrals, medication refills, etc.). Please indicate below how you would like this facility to contact you regarding these matters.

1. Please list daytime telephone number(s) at which you prefer to be reached:

_____ _____ _____

2. Letter or postcard – please give address:

_____

By signing this authorization, I authorize *Heritage Medical Associates* to disclose my protected health information (i.e, test results, medication refills, etc.) to the following individual(s)/family members.

Name: _____ Relationship: _____

_____ _____

_____ _____

Can we leave a message regarding your protected health information at the number(s) you have provided above?
_____ Yes _____ No

I understand that the above information was collected to ensure the privacy of the patients of Heritage Medical Associates. I have reviewed the Notice of Privacy Practices Policy, located in my physician's waiting room and heritagemedical.com/privacy. I further understand that I have the right to revoke this authorization in writing at any time or can update this information at any time by completing another form. By signing this form, I am giving my permission to this facility to contact me in the manner indicated above and acknowledge that I have reviewed the Notice of Privacy Practices Policy. I recognize that I may sign this at the time of my appointment.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Patient Representative / Signature: _____ Relationship to Patient: _____

Patient Name _____ Date of Birth _____

Preferred Name _____

Local Pharmacy _____ Phone _____

Mail Order Pharmacy _____ Phone _____

During my visit, I would like to discuss:

1. _____

2. _____

3. _____

Surgical History

_____ _____ _____ _____

_____ _____ _____ _____

Allergies

☐ No known drug allergies

_____ _____ _____ _____

_____ _____ _____ _____

Medications

_____ _____ _____ _____

_____ _____ _____ _____

Medical History

_____ _____ _____ _____

_____ _____ _____ _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow

Occupation / Work Status: _____

Heritage Medical Associates

Patient Name _____ Date of Birth _____

Tobacco Use

☐ Never Smoked ☐ Current Smoker ☐ Previous Smoker ☐ Current Chew / Dip

Pack / Day _____ Year Quit _____

Are you exposed to secondhand smoke? ☐ Yes ☐ No

Alcohol Use ☐ Yes ☐ No Drinks / Week _____

Regular Exercise ☐ Yes ☐ No

If so: More or less than last year? _____ How often? _____ How long? _____ What type? _____

Have you fallen recently? ☐ Yes ☐ No

Do you have difficulty with bathing or grooming? ☐ Yes ☐ No

Do you have difficulty with eating or meal preparation? ☐ Yes ☐ No

Do you have a Living Will? ☐ Yes ☐ No

Do you have: ☐ Difficulty Seeing ☐ Difficulty Hearing

☐ Other _____

Is drug use a concern for you or for others? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No

Do you wear a seatbelt? ☐ Yes ☐ No

Do you have any life stressors that may be affecting your health? ☐ Yes ☐ No

Are you at high risk for sexually acquired diseases including HIV? ☐ Yes ☐ No

How do you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Persons in Home / Lives With:

☐ Alone ☐ Spouse ☐ Child(ren)

☐ Sibling ☐ Grandchildren ☐ Parent Other _____

Nutrition / Diet

☐ No Particular Diet ☐ Poor ☐ Well-balanced ☐ Vegetarian

Other: _____

Sleep Habits

☐ No Issues ☐ Difficulty Sleeping Hours / Night _____

Heritage Medical Associates

Patient Name _____ Date of Birth _____

Personal and Family History

	Cancer	Dementia	Depression	Diabetes	Heart Disease	High Cholesterol	Hypertension	Liver Disease	Mental Illness	Stroke	Substance Abuse
Yourself	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Sibling(s)	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Child(ren)	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐		☐	
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐		☐	

Date of Most Recent

Eye Exam _____ Dental Exam _____ Shingles Vaccine _____

Bone Density Test _____ Flu Vaccine _____ Tetanus Vaccine _____

Colonoscopy _____ Pneumonia Vaccine _____

Women Only: Last Menstrual Period _____ Pap Smear _____ Mammogram _____

Do you experience leakage or loss of urine with a laugh, cough or sneeze? ☐ Yes ☐ No

Does anyone hurt you or make you feel afraid? ☐ Yes ☐ No

Overall pain presence in daily life:	0 1	2 3	4 5 6	7 8 9	10
	No Pain	Mild	Moderate	Severe	Unbearable

Heritage Medical Associates

REVIEW OF HEALTH PROBLEMS

Patient Name _____ Date of Birth _____

Please check if you have RECENTLY had any of the following:

☐ Appetite Loss
☐ Chills
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Weight Gain (Amount _____)
☐ Weight Loss (Amount _____)

☐ Changes in Wart/Mole
☐ Dryness
☐ Excessive Sweating
☐ Hives
☐ Itching
☐ New Lesions
☐ Nail Changes
☐ Rash

☐ Blurred Vision
☐ Glaucoma
☐ Itchy Eyes
☐ Visual Loss
☐ Wears Glasses / Contact Lenses

☐ Hearing Loss
☐ Ear Discharge
☐ Ear Pain
☐ Ringing in Ears

☐ Nose Bleeds
☐ Nasal Congestion
☐ Post Nasal Drainage
☐ Sneezing
☐ Seasonal Allergies
☐ Hoarseness
☐ Oral Ulcers
☐ Sore Throat

☐ Cough
☐ Shortness of Breath
☐ Wheezing

☐ Breast Mass
☐ Breast Pain
☐ Breast Swelling
☐ Nipple Discharge

☐ Chest Pain
☐ Irregular Heartbeat
☐ Leg Pain and/or Swelling
☐ Rapid Heart Rate

☐ Abdominal Pain
☐ Bloating
☐ Bloody Stools
☐ Change in Bowel Habits
☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Heartburn
☐ Indigestion
☐ Nausea / Vomiting

☐ Blood in Urine
☐ Difficult Urination
☐ Frequent Urination
☐ Impotence
☐ Incontinence
☐ Kidney Stone
☐ Painful Urination
☐ Penile Lesions/ Ulcers
☐ Vaginal Bleeding
☐ Vaginal Discharge

☐ Backache
☐ Joint Pain
☐ Joint Stiffness
☐ Joint Swelling
☐ Muscle Cramps
☐ Muscle Pain
☐ Muscle Weakness

☐ Decreased Memory
☐ Difficulty Speaking
☐ Dizziness
☐ Fainting / Passing Out
☐ Headaches
☐ Muscle Spasm
☐ Numbness
☐ Seizures
☐ Tremor / Shakiness
☐ Unsteadiness

☐ Feeling of Depression
☐ Anxiety
☐ Early Awakening
☐ Inability to Concentrate
☐ Mood Changes
☐ Stress
☐ Trouble Falling Asleep

☐ Feeling Excessively Cold
☐ Excessive Thirst
☐ Excessive Urination
☐ Sweating (Heat Intolerance)
☐ Thyroid Problems

☐ Anemia (Low Blood Count)
☐ Easy Bleeding
☐ Easy Bruising
☐ Enlarged Lymph Nodes

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1. Have you lost interest in things that normally bring you pleasure? ☐ Yes ☐ No

2. Have you felt depressed or down or hopeless within the last 2 months? ☐ Yes ☐ No

If you answered yes to either question above, please answer the following questions in the way that best describes how you have felt over the past two weeks:

	Not at all	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thinking that you would be better off dead or that you want to hurt yourself in some way.	0	1	2	3

STAFF TO COMPLETE: _____ + _____ + _____ + _____

= _____

10. If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult