

Maltman Medical Center Health Information Questionnaire

Name _____ Date Of Birth _____

Male _____ Female _____ Marital Status _____

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 its 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 provide 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

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/No
Live alone or with others alone/with others
Advance Directive Yes/No
Are you currently employed? Yes/No
Occupation _____
General stress level? Low/Med/High
Number of Children _____
Alcohol intake Mild/Mod/Heavy
Caffeine intake Mild/Mod/Heavy
Illicit Drugs? Yes/No
List Drugs _____

Exercise level Mild/Mod/Heavy
Diet Regular/Healthy/Low Carb/Low Sugar
Hard of Hearing/deaf one/both ears Yes/No
Legally Blind Yes/No
Sexually active? Yes/No
Protected Sex? Yes/No
Smoking status Yes/No
Smoking how much? _____
Has smoked since age _____
Passive smoke exposure? Yes/No
Chewing Tobacco? Yes/No
Tobacco years of use _____

GYNECOLOGICAL History

Last PAP _____
Any Abnormal PAP Yes/No
OBGYN MD _____
Had HPV Vaccine? Yes/No
Sexually Active? Yes/No
Change in partner in last 6 mths? Yes/No
History of STI/STD's Yes/No
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 Partial/Full
Ovaries Remaining Left/Right
Approx. Year _____

SURGICAL History

PAST MEDICAL HISTORY

ADD/ADHD	Yes/No
AIDS/HIV	Yes/No
Abuse/Domestic Violence	Yes/No
Acid Reflux (GERD)	Yes/No
Acne	Yes/No
Allergies (Food, Seasonal, Environment)	Yes/No
Allergies/Hayfever	Yes/No
Anemia	Yes/No
Anesthesia Complications	Yes/No
Anxiety Disorder	Yes/No
Arthritis	Yes/No
Asthma	Yes/No
Autism Spectrum Disorder(ASD)	Yes/No
Autoimmune Disease	Yes/No
Bedwetting	Yes/No
Birth Defects or Inherited Disease	Yes/No
Bladder/Kidney Problems	Yes/No
Blood Diseases	Yes/No
Blood Transfusion	Yes/No
Breast Cancer	Yes/No
Breast Problem	Yes/No
COPD	Yes/No
Cancer	Yes/No
Cervical Cancer	Yes/No
Chicken Pox	Yes/No
Chronic Ear Infections	Yes/No
Congestive Heart Failure	Yes/No
Constipation	Yes/No
Coronary Artery Disease	Yes/No
Depression	Yes/No
Depression/Postpartum	Yes/No
Dermatologic Disorders	Yes/No
Developmental or Behavioral Disorders	Yes/No
Diabetes	Yes/No
Difficulty Swallowing	Yes/No
Diverticulitis	Yes/No
Drug/Latex Allergies	Yes/No
Ear or Hearing Problems	Yes/No
Eating Disorder	Yes/No
Eczema	Yes/No
Endometriosis	Yes/No
Fibromyalgia	Yes/No
GI Problems	Yes/No

Gestational Diabetes	Yes/No
Gout	Yes/No
Headaches	Yes/No
Heart Disease	Yes/No
Heart Problems	Yes/No
Hematologic Disorders	Yes/No
Hepatitis	Yes/No
Hepatitis/Liver Disease	Yes/No
High Cholesterol	Yes/No
History of STI/STD	Yes/No
History of Abnormal PAP	Yes/No
Hospitalizations	

Hypertension	Yes/No
Hyperthyroidism	Yes/No
Hypothyroidism	Yes/No
Infertility	Yes/No
IV Drug Use	Yes/No
Kidney Stones	Yes/No
Kidney Disease	Yes/No
Liver Disease	Yes/No
Lung Disease	Yes/No
MRSA Exposure	Yes/No
Meniere's Disease	Yes/No
Mental Disorder	Yes/No
Muscle, Joint, Bone Problems	Yes/No
Neurologic/Epilepsy	Yes/No
Osteopenia	Yes/No
Osteoporosis	Yes/No
Ovarian Cancer	Yes/No
Polycystic Ovaries	Yes/No
Pre-Eclampsia	Yes/No
Pulmonary (TB, Asthma)	Yes/No
Reflux/GERD	Yes/No
Seizures/Epilepsy	Yes/No
Skin Problems	Yes/No
Stroke	Yes/No
Thrombophilias	Yes/No
Trauma/Violence	Yes/No
Tuberculosis	Yes/No
Varicosities	Yes/No
Vision/Eye Problems	Yes/No

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? Yes/No Family

History of Prostate Cancer? Yes/No 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: _____

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	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 or 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 — or that you are a failure or 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 the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, 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

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:** () _____ - _____

Facility/Provider to Release: _____

Covering the period (s) of health care: ____/____ to ____/____

INFORMATION TO BE DISCLOSED: ____ Complete Health Record

OR ONLY THE FOLLOWING: ____ History & Physical ____ Progress Notes ____ Billing/Financial

____ Labs/Imaging ____ Consult Reports ____ Other: _____

Facility/Provider to Receive:

____ Maltman Medical Center 9051 Executive Park Dr Suite 500 Knoxville, TN 37923

P: 865-337-7793 F: 865-240-3539

____ Victory Treatment Program 9051 Executive Park Dr Suite 202 Knoxville, TN 37923

P: 865-337-7812 F: 865-240-3539

For the purposes of: Continuing Patient Care 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 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:** ____/____/____