Hamblen Primary Care
1633 W. Morris Blvd Ste A
Morristown, TN 37813
423-492-6700 ph
423-586-9988 fax

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #		Other Medical Providers			
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White				Language		
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address			Work Phone #			

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone / Cell Phone / Work Phone	Relationship to patient		

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

Hamblen Primary Care
Morristown, TN

Dear Patient:

Please be advised the Hamblen Primary Care is not taking new patients for chronic pain management.

This includes the use of:

Soma
Percocet
Hydrocodone
Oxycodone, or any other long-term opioid (Narcotic) treatment
Examples: Morphine, Dilaudid, Opana, and Embeda
Anxiety medications to include: benzodiazepines (alprazolam, clonazapam, diazepam, lorazepam, or others in this group of medications).

We do not do referrals to any Pain Management Clinics. We are willing to see you for your regular primary and preventative care, but will not prescribe the above medications.

If you feel you need this type of care, we recommend you seek care elsewhere. These medications will not be prescribed at your visit.

Thank you.

Hamblen Primary Care

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Hamblen Primary Care

Covenant HEALTH

Patient Health Assessment Questionnaire

Date: _____ ◻ Male ◻ Female **Age:**_____

NAME: _____ DOB: _____
Status: ◻ Married ◻ Single ◻ Divorced ◻ Widowed
Emergency Contact Person: _____ **Phone:**_____
Current Occupation: _____
Any specific problems or concerns that you would like to discuss at this visit?
_____
_____
_____

List all present MEDICATIONS (including over the counter meds):
_____
_____
_____
_____

List all ALLERGIES: _____
_____

List date you last had:
_____ TB Skin Test
_____ Tetanus
_____ Flu Vaccine
_____ Pneumonia Vaccine
_____ Other: _____

Yes	No		
		Do you smoke?	# Packs/day #years
		Chew tobacco/snuff?	
		Use illicit drugs?	Ever treated for substance abuse? ◻ Yes ◻ No
		Drink Alcohol?	Preferred drink: # day week
		Drink Caffeine?	# Cups per day
		Wear glasses?	Date last exam:
		Wear dentures?	Date last exam:
		Do you wear seatbelts?	
		Do you participate in sports? What?	
		Do you exercise on regular basis?	

Hamblen Primary Care

Covenant HEALTH

Patient Health Assessment Questionnaire

Name: _____

MEDICAL HISTORY: List any conditions you are currently or have been receiving treatment:

_____

_____

SURGERIES: List all operations you have had:

_____

_____

Past HOSPITALIZATIONS: List all hospitalizations not for surgery:

_____

_____

FAMILY HISTORY:

	Living?		Age:	Medical Problems:
Mother	Y	N		
Father	Y	N		
Brother/Sisters	Y	N		
	Y	N		
	Y	N		

ANY OTHER FAMILY HISTORY OF:

Yes/No			Yes/No		
		Heart Attack			Lung Disease
		Heart Disease			Kidney Disease
		High Blood Pressure			Thyroid Disease
		Stroke			Seizures
		Cholesterol Problems			Bleeding Disorder
		Diabetes			Cancer

OTHER: _____

FEMALES: Complete the information below:

	First day of last menstrual period			# times pregnant / ____ # Births
	Date of last Mammogram			Do you examine your breasts monthly?
	Date of last PAP SMEAR			Any history of abnormal pap smears?
Yes/No		Yes/No		
	Missed periods			Pain with periods
	Vaginal discharge			Pain with Intercourse
	Vaginal Pain			Irregular Bleeding

MALES: Answer questions below:

Yes/No		Yes/No		
	Do you examine your testicles monthly?			Any problems with achieving/maintain Erection?
	Problems with testicular pain?			Change in stream?
	Pain with urination?			Night Problems?

List any other concerns you may have:

_____

Health Maintenance Questionnaire

Patient Name_____(please print)

Date of Birth_____Today's Date_____

Have you had a Flu shot? _____YES ____NO When_____Provider_____

Have you had a Pneumonia shot? _____YES_____NO When_____Provider_____

Have you had a Colonoscopy? _____YES_____NO When_____Provider_____

Have you had a Sigmoidoscopy? _____YES_____NO When_____Provider_____

Have you had a Shingles shot? _____YES_____NO When_____Provider_____

Do you see any specialists? _____YES____NO Provider(s)_____

Have you been to the ER since your last visit? ____YES____NO
When_____Hospital_____

Have you been hospitalized since your last visit? ____YES____NO
When_____Hospital_____

Diabetics ONLY

Have you had a diabetic foot exam? ____YES____NO When_____Provider_____

Do you see a Podiatrist? ____YES____NO When_____Provider_____

Do you see an Optometrist? ____YES____NO When_____Provider_____

Males ONLY

Date of last PSA_____Provider_____

Females ONLY

Date of last PAP Smear _____Provider_____

Date of last Mammogram_____Provider/Facility_____

PATIENT NAME:_____ **DOB:**____/____/____

TO BE COMPLETED BY NURSE

Weight ____ lbs / kgs Height ____ inches / cm

PHQ-2 Depression Screening Questionnaire

How often have you been bothered by the below symptoms the last two weeks?

Feeling Down, Depressed, Hopeless	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Little interest - Pleasure in Activities	O Not at all	O More than half the days
	O Several Days	O Nearly every day

PHQ-9 Detailed Depression Screening Questionnaire

If you selected "Not at all" for both questions above, please ignore this section.

Trouble Falling or Staying Asleep	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Feeling Tired or Little Energy	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Poor Appetite or Overeating	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Feeling Bad About Yourself	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Trouble Concentrating	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Moving or Speaking Slowly	O Not at all	O More than half the days
	O Several Days	O Nearly every day
Thoughts Better Off Dead or Hurting Self	O Not at all	O More than half the days
	O Several Days	O Nearly every day

Medication Adherence

Does the patient have any barriers to medication adherence?
(Ie. Any reason that the patient cannot take medication as prescribed?)

O YES O NO

If YES, the reason is?
- O Financial
- O Transportation
- O Trouble Remembering
- O Health literacy
- O Lack of Confidence
- O Time Constraints
- O Cognitive deficit
- O Functional status impairment
- O Other

Is the patient taking over-the-counter medications?

O YES O NO

Fall Risk Assessment

1. Have you fallen in the last year? O YES O NO
2. Are you worried you might fall? O YES O NO
3. Do you use a cane or walker? O YES O NO
4. Do you need someone to help you get up in the morning? O YES O NO

Tobacco Use:

- ☐ Never (less than 100 in lifetime)
- ☐ 4 or less cigarettes (less than 1/4 pack)/day in the last 30 days
- ☐ 5-9 cigarettes (between 1/4 to 1/2 pack)/day in the last 30 days
- ☐ 10 or more cigarettes (1/2 pack or more)/day in the last 30 days
- ☐ Cigars or pipes daily within the last 30 days
- ☐ Cigars or pipes, but not daily within the last 30 days
- ☐ Smokeless tobacco user within last 30 days
- ☐ Smoker, current status unknown
- ☐ Former smokeless tobacco user, quit
- ☐ Former smoker quit more than 30 days
- ☐ Refused tobacco status screen
- ☐ Unable to assess due to cognitive impairment

Types:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Oral
- ☐ Pipe
- ☐ Smokeless Cigarettes
- ☐ Spit Tobacco
- ☐ SNUS Products
- ☐ Other: _____

Packs Per Day ____

Years Smoked ____

Alcohol:

Use:
- ☐ Never used
- ☐ Deny use
- ☐ Past User
- ☐ Not used since pregnant
- ☐ Used early in pregnancy
- ☐ Unable to assess due to cognitive impairment
- ☐ Current user

Type:
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Other:_____

Frequency:
- ☐ 1-2 times per year
- ☐ 1-2 times per month
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ Daily
- ☐ Several times per day
- ☐ Binge
- ☐ Occasional use
- ☐ Regular use

Advanced Directive

- O Yes
- O No
- O No Advanced Directive, information given
- O Unable to answer at this time
- O Healthcare Proxy
- O Revocation

Patient Preferred Pharmacy

Pharmacy Name

Phone

Covenant HEALTH

ACCOUNT NUMBER: _____

PROVIDER AUTHORIZED TO RELEASE HEALTH INFORMATION (check all that apply):

❑Claiborne Medical Center ❑Cumberland Medical Center ❑Ft. Loudoun Medical Center ❑Ft Sanders Regional Medical Center
❑LeConte Medical Center ❑Methodist Medical Center ❑Morristown Hamblen Health System ❑Parkwest Medical Center
❑Peninsula Behavioral Health ❑Roane Medical Center ❑Thompson Cancer Survival Center ❑Covenant Home Care
❑ Other: _____
□ PENINSULA OUTPATIENT CLINICS: □ Blount □ Knoxville □ Loudoun □ Sevier □ IOP □ WIT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Birth: ___/___/_____ **Date of Death,** if applicable: ___/___/_____ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

The information is to be disclosed to the following persons or organizations (Self or Authorized Receiving Party):

Name/Title: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Purpose: ❑At the request of patient ❑ Legal Purposes ❑Other: _____

INFORMATION TO BE DISCLOSED includes dates of service from _____ to _____

❑ **Entire medical record**

OR

❑ Discharge Summary	❑ Progress Notes	**PENINSULA SPECIFIC:**
❑ History and Physical Exam	❑ EKG/s	❑ Assessment(s)
❑ Consultation Report/s	❑ Photographs, videotapes, or other image	❑ Treatment(s)/Therapies
❑ Operative Report	❑ HIV Test Results and Treatment	❑ Substance Use Disorder
❑ Pathology Report	❑ Mental or Behavioral Health	**OTHER:**
❑ Emergency Room Record	❑ Physical/Occupational/Speech Therapy	
❑ Lab Results	❑ Cardiac Rehabilitation	
❑ Radiology Report/s	❑ Implant Records	

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: 1) One year after the date this authorization is signed **or** 2) On the occurrence of the following event: _____.

I understand I may revoke this authorization at any time by sending a written notice to each provider marked above. Revocation will not affect any uses or disclosures provider(s) may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that there may be a reasonable copying fee, as permitted by applicable law.

SIGNATURE_____ **DATE**____/____/_____**TIME**_____
If signed by patient's legal representative please complete the following and attach appropriate documentation
Printed Name: _____ **Relationship:** _____

FOR PROVIDER USE ONLY

How was identity verified? _____ Copy made? ❑ Yes ❑ No
How was authority verified? _____ Copy made? ❑ Yes ❑ No
By: _____ Title: _____ Date: _____
❑ Picked up ❑ Mailed ❑ Faxed Date: ___/___/_____ Released by: _____