PATIENT REGISTRATION

Gregory K. Hoover, M.D.

DATE: _____

NEW PATIENT: ____
UPDATE: ____

PLEASE COMPLETE ENTIRE FORM PATIENT INFORMATION

NAME: _____
(LAST NAME) (FIRST NAME) (INITIAL)

ADDRESS: _____
(NUMBER) (STREET) (APT) (CITY) (STATE) (ZIP)

DOB: _____ AGE: ___ MALE / FEMALE MARITAL STATUS: _____ HOME PHONE: (____)_____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ CELL # (____)_____

EMPLOYER: _____ OCCUPATION: _____ WK PHONE: (____)_____

REFERRED TO THIS OFFICE BY: _____ PHONE: (____)_____
(IF PHYSICIAN PLEASE PRINT PHYSICIAN'S FULL NAME)

INSURANCE INFORMATION

**** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM ****

PRIMARY INSURANCE: _____

INSURED PERSON: _____ DOB: _____ SSN: _____

EMPLOYER NAME: _____ BUSINESS PHONE: (____)_____

EMPLOYER BUSINESS ADDRESS: _____

SECONDARY INSURANCE: _____

INSURED PERSON: _____ DOB: _____ SSN: _____

EMPLOYER NAME: _____ BUSINESS PHONE: (____)_____

EMPLOYER BUSINESS ADDRESS: _____

GUARANTOR INFORMATION (if different from Patient)

☐ SPOUSE ☐ PARENT ☐ GUARDIAN NAME: _____

EMPLOYER: _____ PHONE: (____)_____

BUSINESS ADDRESS: _____ CELL # (____)_____

MEDICAL HISTORY (Please answer Yes or No)

ON-THE-JOB INJURY: ☐ YES ☐ NO IF YES, DATE OF ACCIDENT: _____ DATE LAST WORKED: _____

MOTOR VEHICLE ACCIDENT: ☐ YES ☐ NO If YES, DATE OF ACCIDENT: _____

TREATED BY ANOTHER DR. FOR THIS PROBLEM? ☐ YES ☐ NO IF YES, WHERE OR WHO: _____

IN CASE OF EMERGENCY

****PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOUR RESIDENCE****

NAME: _____ RELATIONSHIP: _____ PHONE: (____)_____

ADDRESS: _____
(CITY) (STATE) (ZIP)

ASSIGNMENT AND RELEASE

This signature will authorize _____ to provide the indicated Medical/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to _____ all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medical information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: _____ Date: _____

Signature of Patient (or parent): _____ Date: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any amount consistent with the contract or limits defined within your insurance plan.**

IN ORDER TO CONTROL COSTS OF BILLING, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

PATIENT HISTORY

Name: _____ Date: _____

Occupation: _____ Age: _____ Sex: ____

PLEASE TELL US THE REASON FOR TODAYS VISIT INCLUDING BODY PART, RIGH T OR LEFT AND DATE SYMPTOMS BEGAN: _____

_____

_____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM: ☐ NO ☐ YES

If YES, from whom: _____ Date: _____

Were x-rays taken: ☐ No ☐ Yes If YES, what part of body: _____

PAST HISTORY:

LIST CURRENT MEDICATIONS/HERBALS or check ☐ None: _____

_____

LIST ALLERGIES TO MEDICATIONS or check ☐ None: _____

Illnesses: ☐ None ☐ Diabetes I ☐ Diabetes II ☐ Heart Trouble ☐ Hypertension ☐ Emphysema ☐ Asthma ☐ TB ☐ Ulcer ☐ Cancer ☐ Thyroid ☐ Hepatitis ☐ Other (explain)_____

Operations: ☐ None ☐ Tonsillectomy ☐ Appendectomy ☐ Hernia Repair ☐ Hysterectomy ☐ D&C ☐ Hemorrhoidectomy ☐ Gallbladder ☐ Other (explain): _____

Transfusions: ☐ No ☐ Yes (explain): _____

Hospitalizations Other Than Surgery: ☐ No ☐ Yes (explain): _____

FAMILY HISTORY	Age	Living/Deceased	Illnesses/Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			

HABITS: **Tobacco:** ☐ No ☐ Yes Type: _____ How often/How much?_____ **Use Drugs:** ☐ No ☐ Yes

Drink Alcohol: ☐ No ☐ Yes _____drinks per day

REVIEW OF SYSTEMS: **(Check all that apply to TODAY'S visit)**

General
___ Weight loss
___ Weight gain
___ Poor appetite
___ Chills
___ Fevers
___ Night sweats

Skin
___ Rash
___ Hives
___ Lesions

HEENT
___ Hay fever
___ Postnasal discharge
___ Hoarseness
___ Visual problems
___ Hearing loss

Cardiovascular
___ Chest pain (angina)
___ Palpitations (rapid heartbeat)
___ Irregular heartbeat (arrhythmia)
___ Rheumatic fever
___ Swollen ankles (pedal edema)
___ Shortness of breath on exertion
___ Shortness of breath at night

Pulmonary
___ Shortness of breath
___ Wheezing
___ Coughing
___ Coughing up blood (hemoptysis)

Genitourinary
___ Frequent urination (frequency)
___ Urgent urination (urgency)
___ Painful urination (dysuria)
___ Need to awaken to urinate (nocturia)
___ Blood in urine (hematuria)
___ Penile or vaginal discharge
___ Kidney stone pain (renal colic)

Gastrointestinal
___ Indigestion
___ Gas
___ Nausea
___ Vomiting
___ Vomiting blood (hematemesis)
___ Yellow skin
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Black stools (melena)
___ Rectal bleeding

Psychiatric
___ Anxiety
___ Depression
___ Other _____

Lymphatics
___ Lymph node swelling
___ Node tenderness

Endocrine
___ Excessive urination (polyuria)
___ Excessive thirst (polydipsia)
___ Excessive appetite (polyphagia)
___ Heat intolerance
___ Cold intolerance

Neurological
___ Loss of consciousness
___ Headaches
___ Dizziness
___ Seizures (fits)
___ Fainting spells

FEMALES:
Are you pregnant? ☐ No ☐ Yes
Date of last menstrual cycle _____

HEIGHT: _____ **WEIGHT:** _____ **DOMINANCE: Right Hand** ____ **(or) Left Hand** ____

Signature: _____ **Date:** _____

I certify that the information provided above is correct and true.

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: _____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to your appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a $25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Printed Name:_____ DOB:_____

Patient Signature:_____ Date:_____