Tri Cities Health PC

PATIENT REGISTRATION FORM

TODAYS DATE:_____

PATIENT'S LAST NAME:_____FIRST:_____MIDDLE:_____

DATE OF BIRTH:_____ AGE:____ GENDER: MALE/FEMALE/OTHER

CURRENT ADDRESS:_____

PHONE:_____ OK TO RECEIVE TEXT APPT REMINDERS? YES/NO

EMAIL ADDRESS:_____

OCCUPATION:_____ EMPLOYER:_____

IN THE EVENT OF AN EMERGENCY, WHO WOULD YOU WANT US TO CONTACT?

NAME/NUMBER/RELATIONSHIP:_____

HOW DID YOU HEAR ABOUT US? _____

OTHER FAMILY MEMBERS SEEN HERE:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be utilized by Lab Corp, Quest, Boston Heart Diagnostics. I understand that I am financially responsible for any balance. I authorize TCH or insurance company to release any information required to process my claims. This registration will remain valid indefinitely unless repealed in writing by patient.

_____ _____

Patient Signature **Date**

PRIVACY PRACTICES/PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (2 pages) for Tri Cities Health PC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application for Care/Patient Registration) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Printed Patient Name

HEALTH HISTORY

NAME/DOB:_____

OTHER PHYSICIANS SEEN/CLINIC:_____

Please CIRCLE if you are CURRENTLY having any of the following conditions or have had them in the PAST: AIDS/HIV ALCOHOLISM ANEMIA ANOREXIA APPENDICITIS ARTHRITIS ASTHMA BLEEDING DISORDERS BREAST LUMPS BRONCHITIS BULEMIA CANCER CATARACTS CHEMICAL/DRUG DEPENDENCY CHICKEN POX DIABETES EMPHYSEMA EPILEPSY FRACTURES GLAUCOMA GOITER GONORRHEA GOUT HEART DISEASE HEPATITIS HERNIA HERNIATED DISC HERPES HIGH CHOLESTEROL KIDNEY DISEASE LIVER DISEASE MEASLES MIGRAINES MISCARRIAGE MONONUCLEOSIS MULTIPLE SCLEROSIS MUMPS OSTEOPOROSIS PACEMAKER PINCHED NERVES PNEUMONIA POLIO PROSTATE PROBLEMS PROSTHESIS PSYCHIATRIC CARE RHEUMATIC FEVER RHEUMATOID ARTHRITIS SCARLET FEVER STROKE/TIA SUICIDE ATTEMPT THYROID PROBLEMS TONSILLITIS TUBERCULOSIS TUMORS/GROWTHS TYPHOID FEVER ULCERS VAGINAL INFECTIONS VENEREAL DISEASE WHOOPING COUGH BLOOD TRANSFUSIONS OTHER:_____

Do you currently have a health care provider? _____ Who?_____

List any PRESCRIPTION and OTC medications (dose and frequency) that you currently take:_____

_____

_____

List any prior surgeries and hospitalizations (type and date):

_____

List any allergies:_____

List any vitamins/herbs/supplements:_____

Is there a family history (mother, father, or brothers/sisters) of the following?

Heart Disease_____ Diabetes_____Cancer_____
Arthritis_____ Obesity_____ Blood Disorders_____

Do you exercise (circle)? Never Daily Weekly Type: Walk Run Swim Gym

Do your work activities mostly involve: Sitting Standing Light Labor Hard Labor

What is your daily/weekly intake of the following?

Caffeine ___cups/day Alcohol __drinks/wk of _____ (type) Cigarettes ___packs/day # yrs___

Smokeless tobacco__cans/bags per day # yrs ___

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Signature Date

REVIEW OF SYSTEMS

NAME:_____ DOB:_____ DATE:_____

*PLEASE MARK IF YOU HAVE HAD ANY OF THESE SYMPTOMS IN THE LAST MONTH

NEUROLOGICAL/EENT

__MIGRAINES __SLURRED SPEECH

__HEADACHES __RINGING EARS

__ALTERED TASTE/SMELL

__NIGHT BLINDNESS __SORE THROAT

__GINGIVITIS __NOSE BLEEDS

__EAR PAIN

CARDIOVASCULAR

__CHEST PAIN __RACING HEART

__UNUSUAL BEATS __ANEMIA

__SWOLLEN HANDS/FEET/EYES

__DECREASED EXERCISE ENDURANCE

RESPIRATORY

__RECURRENT RESP INFECTIONS

__ASTHMA __CHEST CONGESTION

__WHEEZING __SNEEZING

GASTRO-INTESTINAL

__STOMACH PAIN __CRAMPS

__CONSTIPATION __NAUSEA

__VOMITING __DIARRHEA

__BLOATING __HEARTBURN

MUSCULOSKELETAL

__JOINT PAIN __ARTHRITIS __TICK BITE

__CHRONIC PAINS __MUSCLE ACHES

__MUSCLE SPASMS __TICK BITES

SKIN

__ECZEMA __DERMATITIS __RASHES

__EXCESS SWEATING __BRITTLE NAILS

__HAIR LOSS __EASY BRUISING __SKIN TAGS

__UNUSUAL MOLES OR FRECKLES

__INCREASED BLEEDING __NUMBNESS

__DIABETIC ULCERS

GENITOURINARY

__UTERINE FIBROIDS __OVARIAN CYSTS

__CANCER
(BREAST/OVARY/PROSTATE/OTHER)

__PROSTATE PROBLEMS __HERPES
__ABNORMAL PAP SMEAR

EMOTIONAL/MENTAL/ENERGY

__DEPRESSION __ANXIETY

__MOOD SWINGS __IRRITABILITY

__SUICIDAL THOUGHTS __CONFUSION

__MEMORY LOSS

__FATIGUE __HYPERACTIVITY __STRESS

__RESTLESSNESS __INSOMNIA __SNORES

__DAYTIME SOMNOLENCE __LOW SEX DRIVE

WEIGHT

__DECREASED APPETITE __WT LOSS

__INCREASED APPETITE __WT GAIN

__FOOD CRAVING __BINGE EATING

__UNABLE TO LOSE WEIGHT

International Prostate Symptom Score (I-PSS)

Patient Name: _____ **Date of birth:** _____ **Date completed** _____

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always	Your score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
Total I-PSS Score							

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

PATIENT CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT THERAPY:

Although testosterone replacement therapy (TRT) has been utilized safely and effectively, it is necessary to disclose potential risks. You should also be aware that there are alternatives to testosterone replacement therapy, including not receiving the treatment. It is important that you consider this information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weight your options or consult another health care provider.

Please review the following items, which discuss informed consent. Your clinical provider will attempt to answer all of your questions to your satisfaction. Signing this document indicates that you have read, understand, and agree with each item below.

1. This is my consent for Tri Cities Health, including any physician or nurse practitioner/nurse who works with the practice, to begin treatment for Testosterone Replacement Therapy.
2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as gynecomastia, acne, fat loss, and increased estrogens.
3. I understand that I may retain extra fluid in the body and this may cause problems for patients with heart, kidney, or liver disease.
4. TRT may cause you LH and FSH levels to be severely limited, affecting your fertility. Patients should not be on TRT if attempting to father a child. However, TRT also does not guarantee decreased fertility.
5. Changes in cholesterol levels, red blood cell levels, PSA levels, liver enzymes, and other hormone levels which will be monitored with periodic blood tests.
6. I understand it is my responsibility to be aware of the above complications and let my Tri Cities Health practitioner know when I have a concern.
7. I understand that I will have periodic blood tests to monitor my blood levels.
8. I understand that there is no guarantee as to the result and that if I stop treatment, my condition may return or worsen.
9. I have had an opportunity to discuss with Tri Cities Health and its medical providers, my complete past medical history including any serious health problems and/or injuries. All of my questions concerning risks, benefits, and alternatives have been answered. I am satisfied with the answers.
10. I agree that TRT works best when I change lifestyle habits such as limiting alcohol, stopping tobacco products, exercising, and eating a healthy diet.
11. IMPORTANT: I agree that while a patient at Tri Cities Health, I will not take any type of anabolic steroids, testosterone gel, hormone "boosters", pro-hormones, or any additional testosterone supplementation not provided by Tri Cities Health during my treatment plan. At any time, if use of these items is discovered, I understand that I may be dismissed as a patient of Tri Cities Health.

Printed Name/Signature/Date: _____

Tri Cities Health Testosterone Replacement Therapy

In order to be treated for hypogonadism (low T) at Tri Cities Health, patients must **remain on schedule** for injections and obtain labs as ordered to continue treatment. A lapse of treatment of **more than two weeks** will result in discontinuation of therapy due to the fact that erratic therapy does not improve hypogonadism. To restart, new labs will be obtained and dosing will follow new patient regimen.

Testosterone Replacement Therapy does not achieve appropriate results unless protocols are followed. Intermittent injections result in fatigue and large fluctuations of testosterone levels, and do not improve the health of the individual.

Also, primary care visits will be billed separately for patients no longer on the TRT protocol. **If you come in beyond the two week schedule- do not expect to receive TRT and Primary Care on the same day.**

*Please discuss with office manager or your health care provider if you have questions.

Dr. Kimberly McMurtrey APRN, FNP-C, DNP

Patient Signature:_____ Date:_____

TRI CITIES HEALTH HIPAA AUTHORIZATION FORM FOR FAMILY/FRIENDS

I, _____(NAME) _____(DOB), give permission to all my healthcare and medical services providers and payers to disclose and release my protected health information described below to:

Name(s) and Relationship: (May put "No one" if you do not wish us to release any information)

_____

_____

Healthcare information to be disclosed: (check all that apply)

( ) My complete health care record (including but not limited to diagnoses, lab results, prognosis, treatment, billing, for all conditions) OR

( ) My complete health care record, as above, with the exception of the following information:

( ) Mental health records ( ) Communicable diseases (including HIV/AIDS)

( ) Alcohol/drug abuse treatment ( ) Other: please specify_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization is effective until ( ) _____ OR ( ) All past, present, future time periods.

*You may revoke this authorization at any time by notifying your health care provider in writing.

_____

Printed Name of the individual giving this authorization Date

_____

Signature of the individual giving this authorization Relationship to patient

Authorization to Release Healthcare Information

Tri Cities Health PC

Dr. Kimberly McMurtrey FNP-C, DNP

2208 W Elk Ave

Elizabethton TN 37658

Phone: 423-543-7000

Fax: 423-543-7002

*Hours: Tues, Wed, Thursday 8:30-4:30pm

Patient Name:_____DOB_____

___ I request and authorize_____ to release healthcare information of the above named patient to Tri Cities Health PC.

___I request and authorize Tri Cities Health to release specified healthcare information to _____.

This request and authorization applies to:

___Healthcare information re:_____

___All healthcare information.

___YES___NO I authorize the release of my STD, HIV/AIDS testing, whether positive or negative, to the persons listed above. I understand that the persons listed above will be notified that I must give specific written permission before the disclosure of test results to anyone.

___YES___NO I authorize the release of any records regarding drug, alcohol, or mental health treatment to the persons listed above.

Note: Sexually transmitted Disease as defined by law , RCW 70.24 et seq. includes herpes, herpes simplex, human papilloma virus, genital wart, condyloma, nonspecific urethritis,syphilis, VDRL, chancroid, LGV, HIV, AIDS, and gonorrhea.

Patient Signature/Date_____