APPALACHIAN
Regional Medical Associates
A Division of Appalachian Regional Healthcare System
at Appalachian Regional Internal Medicine Specialists

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

## Patient Registration

**Please Print Patient Name:** First _____ M/I _____ Last _____

**Gender:** ☐Male ☐ Female **Date of Birth:** ____/____/_____ **Social Security #:** _____-_____-_____

**Mailing Address:** Street- _____

City- _____ State- _____ Zip Code- _____

**Home Phone #:** _____ **Work Phone #:** _____

**Cell #:** _____ **E-mail:** _____

**Employer/Occupation:** _____

**Marital Status:** ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Partner

**How did you hear about us?**
☐ Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV
☐ARHS Website ☐Other _____

**What is your ethnicity?** ☐Hispanic or Latino ☐ Not Hispanic or Latino

**Select one or more races to indicate what you consider yourself to be:** ☐Asian ☐ White
☐ American Indian or Alaskan Native ☐ Black or African American
☐Native Hawaiian or other Pacific Islander ☐ Other: _____

**Preferred language?** ☐English ☐Other: _____

**Which Pharmacy do you use:** _____

**Emergency Contact Name and Relationship:** _____
**Emergency Contact Number:** _____

If patient is a minor:
**Please Print Guardian Name:** First _____ M/I _____ Last _____

If someone else is responsible for the bill:
**Patient's relationship to Guarantor:** _____
**Guarantor's Name:** First _____ M/I _____ Last _____

**Mailing Address:** Street- _____

City- _____ State- _____ Zip Code- _____

**Date of Birth:** ____/____/_____ **Social Security #:** _____-_____-_____ **Phone #:** _____

**Employer:** _____ **Employer Phone#:** _____

**Referring Doctor:** _____ **Primary Care Provider:** _____


Effective Date: 03/01/2012
Revised Date: 07/03/2017
Form Number: 10645

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

# *Authorization to Obtain Medication History*

Patient Name: _____

DOB: _____

SSN: _____

Address: _____

_____

By signing below, I hereby authorize Appalachian Regional Medical Associates to obtain the last 2 years of Medication History related to the patient above, from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

This release may be revoked upon written request of the patient or legal guardian. This release will also be revoked if the patient transfers care to another provider outside of Appalachian Regional Medical Associates.

_____
Date of Authorization

_____
Patient/Legal Representative or Parent/Legal Guardian Print Name

_____
Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Appalachian Regional Medical Associates may not condition the provision of treatment, payment, enrollment in health plan or eligibility for benefits on the provision of this automation.


Effective Date: 10/10/2012
Revised Date:11/05/2012
Form Number: 10531

R-10537

APPALACHIAN
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

# Authorization of Release and Consent

**Name:** _____ **Date:** ___/____/____

## Release of Medical and/or Financial Information: Persons authorized to receive information

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Name: _____ Relationship:_____ Phone: _____
☐Medical (i.e. results of lab tests/ x-rays) ☐Appointment information ☐Financial ☐Other

Initial

### Consent to Receive Communication on Cell Phone

_____ ☐ I do hereby authorize ARHS and its subsidiaries to call my cell phone to communicate with me or to leave a message for me for financial reasons such as balance due, new insurance and financial assistance as well as appointments, wellness checkups, pre-registration, lab results, and any other healthcare related information.

**My cell phone number is:** _____

ARMA and its subsidiaries may also send me messages me via:
☐Email: _____ ☐Other: _____

Initial

### Consent for Medical Treatment

_____ ☐ Knowing that I am seeking medical care/medical testing, I hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment by my physician, his/her assistants or his/her designees as may be necessary in his/her judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledged that no guarantees have been made as to the results of treatments or examinations in the hospital/practice. This form has been fully explained to me and I certify that I understand its contents

Initial

### Assignment of Insurance Benefits

_____ ☐ I hereby authorize direct payment of surgical and medical benefits to the physician or to whomever he/she designates and I also authorize direct payment of all other benefits to ARHS and its subsidiaries. The benefits referred to herein would be payable to me if I did not make assignment and include major medical insurance. I understand that I am personally responsible to practice and physician respectively for charges not covered by this agreement. I also authorize ARHS and my attending physician to release any medical information required in processing of applications for final coverage for services rendered.

Initial

### Medicare-Medicaid Patient's Certification

_____ ☐ I do hereby authorize ARHS and its subsidiaries to release information and request payment. I certify that the information given by me in applying for payment under Titles XVIII and XIX of Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.


Effective Date: 03/01/2012
Revised Date: 08/16/2016
Form Number: 10623

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

***Authorization of Release and Consent***

Initial

**3rd Party Billing Agreement**

_____ ☐ I acknowledge and understand that in addition to a bill from Appalachian Regional Medical Associates, patients who accept the services for pathology, laboratory, or imaging will receive a separate bill from the respective service provider.

Initial

**Notice of Privacy Practices and the Financial Information**

_____ ☐ I have received and understand the notice of Privacy Practices and the Financial Information brochures.

Initial

_____ ☐By signing below, I hereby authorize Appalachian Regional Medical Associates to obtain the last 2 years of Medication History related to the patient above, from the community pharmacies and/or pharmacy benefit managers for the purpose of continuity of care.

## I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

## I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.
- The right to revoke this authorization at any time.

_____ _____

*Signature of Patient* *Date* *Time*

_____ _____

*Signature of Guarantor* *Date* *Time*

_____

*Description of Personal Representative's Authority (attach necessary documentation)*


Effective Date: 03/01/2012
Revised Date: 08/16/2016
Form Number: 10623

APPALACHIAN
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

# Patient History Survey

Name: _____ Date: _____

Who is your regular physician? _____

Chief Complaint (briefly state reason for seeing us): _____

_____

How long have you had this problem? _____

**Medications:** (Please include both prescription medicines and over the counter medications such as those for headache, bowels, etc. as well as any herbal therapies, vitamins or injections):

| Currently Taking (name, dose) | Taken within the past 6 months |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |
| 6. | 6. |
| 7. | 7. |
| 8. | 8. |

**Drug Allergies (rash, fever, wheezing or other reaction):**

| Drug: | Reaction: | Year Occurred: |
|---|---|---|
| | | |
| | | |

| Surgeries: | Date (approx.) | Surgeon | City |
|---|---|---|---|
| Appendectomy: | | | |
| Hysterectomy: | | | |
| Tonsillectomy: | | | |
| Other: _____ | | | |


Effective Date: 12/13/2012
Revised Date: 07/30/2015
Form Number: 10683

APPALACHIAN
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At Appalachian Regional Internal Medicine Specialists

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

**Injuries (broken bones, accidents):** _____

_____

**Recent Hospitalizations (within last three years):**
Date (approx.) Reason:

_____ _____

_____ _____

**Sleep Schedule:** Retire: _____ Arise: _____

**Childhood Diseases:**

| | | |
|---|---|---|
| Rheumatic Fever | ☐ Yes ☐ No | Date: |
| Hepatitis | ☐ Yes ☐ No | Date: |
| Scarlet Fever | ☐ Yes ☐ No | Date: |
| Other | ☐ Yes ☐ No | Date: |
| Have you ever had a blood transfusion? ☐ Yes ☐ No Date: | | |

**Have you or any of your relatives had any of these diseases? If so, please list your relationship to the person with the disease:**

| | Self | Relative | | Self | Relative |
|---|---|---|---|---|---|
| Gout | | | High Blood Pressure | | |
| Lupus | | | Fibromyalgia | | |
| Rheumatoid Arthritis | | | Diabetes | | |
| Osteoarthritis | | | Tuberculosis | | |
| Psoriasis | | | Kidney Disease | | |
| Epilepsy/Seizure | | | Kidney Stone | | |
| Migraine | | | Thyroid Disease | | |
| Cancer (kind?) | | | Osteoporosis | | |
| Heart Disease | | | Other (specify) | | |

**Social History:** Marital Status: _____ Birth date: _____
Where were you born? _____ Education: High School _____
College/ Professional School: _____ Degree _____
Occupation (current): _____

**Children:**

| Name | Age | Health Status |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you traveled outside the Southeast in the past 3 years? _____
If so, when and where?_____


Effective Date: 12/13/2012
Revised Date: 07/30/2015
Form Number: 10683

T-10683

APPALACHIAN
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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

## Rheumatic Systems Review:

| | Yes | No | Comments |
|---|---|---|---|
| Ever been told you have gout? | | | |
| Ever had tender joints? | | | |
| Any swollen joints? | | | |
| Any hot or red joints? | | | |
| Any nodules or lumps about any joints? | | | |
| Any prolonged morning stiffness? | | | |
| Any jaw pain with chewing? | | | |
| Any sudden change in vision? | | | |
| Any scalp tenderness? | | | |
| Any unusual headaches? | | | |
| Any muscle pain? | | | |
| Any difficulty with climbing stairs? | | | |
| Difficulty using arms? | | | |
| Trouble thinking? | | | |
| Persistent sadness or irritability? | | | |
| Have you been told that you snore? | | | |
| Any trouble with swallowing? | | | |
| Any thickness or tightening of skin? | | | |
| Do your fingers blanche or turn white on exposure to cold? | | | |
| Does sun exposure give you fever, rash or make you ill? | | | |
| Any large loss of scalp hair lately? | | | |
| Is your mouth persistently dry? | | | |
| Any persistent sandy or gritty sensation in your eyes? | | | |
| Have you ever had a blood clot? | | | |
| Do you have recurrent ulcers/sores of the mouth or genitals? | | | |
| Any episode(s) of painful/bloodshot eyes? | | | |
| Any problem with heel pain? | | | |
| Ever had bloody diarrhea? | | | |
| Any hot flashes / flushing or nightsweats? | | | |
| Any tick bites? | | | |


Effective Date: 12/13/2012
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Form Number: 10683

T-10683

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient History Survey

| *Rheumatic Systems Review Continued* | Yes | No | Comments |
|---|---|---|---|
| Have you ever had pleurisy (hurting when you take a deep breath)? | | | |
| Have you had hepatitis? | | | |
| Do you have frequent back pain? | | | |
| Have you ever had a TB skin test? | | | |
| Have you ever had psoriasis? | | | |
| Do you smoke? | | | |
| Do you drink alcohol? | | | |
| Do you exercise regularly? | | | |
| **Women**: Regular menstrual periods? | | | |
| Menopause? If so, at what age? | | | |
| Using birth control pills? | | | |
| Ever had a miscarriage? | | | |
| **Men:** History of penile discharge? | | | |
| Penile rash or ulcers? | | | |
| **Patients with Rheumatoid Arthritis:** | | | |
| Have you taken: | | | |
| Plaquenil? | | | |
| Azulfidine | | | |
| Methotrexate (Rheumatrex)? | | | |
| Imuran (Azathioprine)? | | | |
| Leflunomide (Aava)? | | | |
| Remicade? | | | |
| **Back pain patients only:** | | | |
| Did your back pain begin shortly after an injury? | | | |
| Did your back pain begin suddenly? | | | |
| Has your back pain ever persisted for more than three months? | | | |
| Has your back been especially stiff in the morning? | | | |
| Is your back pain better relieved by rest or by exercise? | | | |
| At what age did your back pain begin? | | | |


Effective Date: 12/13/2012
Revised Date: 07/30/2015
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T-10683

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Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

# Patient Evaluation

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

**Instructions:** This brief form provides a record of your health status today. Please try and answer each question even if you've already answered a similar question before. There are no right or wrong answers – just answer exactly as you think or feel.

1. Please check ( ✓ ) the ONE best answer for your abilities at this time:

| **Over the last week**, were you able to: | Without **Any** Difficulty | With **Some** Difficulty | With **Much** Difficulty | **Unable** To Do |
|---|---|---|---|---|
| a. Dress yourself, including tying shoelaces and doing buttons? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| b. Get in and out of bed? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| c. Lift a full cup or glass to your mouth? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| d. Walk outdoors on flat ground? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| e. Wash and dry your entire body? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| f. Bend down to pick up clothing from the floor? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| g. Turn regular faucets on and off? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| h. Get in and out of a car, bus, train, or airplane? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| i. Walk two miles or three kilometer, if you wish? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| j. Participate in recreational activities and sports as you would like, if you wish? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| k. Get a good night's sleep? | ☐ 0 | ☐ 1.1 | ☐ 2.2 | ☐ 3.3 |
| l. Deal with feelings of anxiety or being nervous? | ☐ 0 | ☐ 1.1 | ☐ 2.2 | ☐ 3.3 |
| m. Deal with feelings of depression or feeling blue? | ☐ 0 | ☐ 1.1 | ☐ 2.2 | ☐ 3.3 |

**For Office Use Only**

1.a-j FH (0-10): _____

| | |
|---|---|
| 1= 0.3 | 16= 5.3 |
| 2= 0.7 | 17= 5.7 |
| 3= 1.0 | 18= 6.0 |
| 4= 1.3 | 19= 6.3 |
| 5= 1.7 | 20= 6.7 |
| 6= 2.0 | 21= 7.0 |
| 7= 2.3 | 22= 7.3 |
| 8= 2.7 | 23= 7.7 |
| 9= 3.0 | 24= 8.0 |
| 10= 3.3 | 25= 8.3 |
| 11= 3.7 | 26= 8.7 |
| 12= 4.0 | 27= 9.0 |
| 13= 4.3 | 28= 9.3 |
| 14= 4.7 | 29= 9.7 |
| 15= 5.0 | 30= 10 |

2. PH (0-10): _____

4. PTGL (0-10): _____

RAPID 3 (0-30): _____

2. How much pain have you had because of your condition **over the past week**? Please indicate how severe your pain has been on a scale of 1 to 10:
   _____

3. How much of a problem has **unusual** fatigue or tiredness been for you **over the past week** on a scale of 1 to 10?
   _____

4. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing on a scale of 1 to 10:
   _____

Pharmacy: _____ Date: _____


Effective Date: 06/05/2015
Revised Date: 07/30/2015
Form Number: 10973