Dear patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website (huntsvillehospital.org/find-a-doctor/huntsville-hospital-physicians-offices) should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please call our office at the number on the left to schedule your new patient appointment prior to completing the New Patient Forms found on our website. We prefer that you mail, fax or drop off the completed forms prior to your appointment. If unable to do so, please bring the completed forms with you to your appointment. Bring your identification cards, insurance card and medication bottles, as well as your co-payments and/or deductibles the day of your visit.

We ask that all new patients arrive 30 minutes prior to your appointment time, so you can be seen by the provider at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be 15 minutes or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Sherri Telaga, RN
Practice Administrator
Huntsville Hospital Physician Care at Bailey Cove
Patient

Name: ___________________________________________ Referral by: ________________________________
Address: ______________________________________ City: ___________________ State: ____ Zip: ________
Home phone: ____________________ Cell phone: ____________________ Work phone: ____________________
DOB: ___________________________ SSN: ___________________________ Sex: □ M  □ F
Email address: _____________________________________________________________________________________
Patient’s occupation: ___________________________ Employer: ________________________________________
Employer’s address: _______________________________________________ Employer phone: ____________
Spouse’s name: _______________________________ Spouse’s DOB: ____________ Spouse’s SSN: ____________
Spouse’s occupation: __________________________ Employer: ________________________________________
Employer’s address: _______________________________________________ Employer phone: ____________
In case of emergency, notify: _____________________________________________________________________ Relationship: _______________________
City: _______________________________________ State: _____________ Phone: ________________________

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office
for treatment:
Name: ________________________________ Relationship: _____________ Phone: ________________________
Name: ________________________________ Relationship: _____________ Phone: ________________________
Name: ________________________________ Relationship: _____________ Phone: ________________________

Insurance (provide patient information unless patient is a minor, then provide guarantor’s information)

Insurance name: __________________________________ Relationship to patient: ______________________
Subscriber’s name: __________________________________ Copay amount: ___________________________
Subscriber ID/Contract Policy #: __________________ Group #: ______________________
Subscriber’s SSN: _______________________________ Subscriber’s DOB: __________________________
Subscriber’s Employer: ___________________________ Employer’s phone: _________________________

Insurance name: __________________________________ Relationship to patient: ______________________
Subscriber’s name: __________________________________ Copay amount: ___________________________
Subscriber ID/Contract Policy #: __________________ Group #: ______________________
Subscriber’s SSN: _______________________________ Subscriber’s DOB: __________________________
Subscriber’s Employer: ___________________________ Employer’s phone: _________________________

Person responsible for this account: ________________________ Phone: ____________________________

I agree payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges,
deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency
for collection, I will be responsible for all collection fees, court costs and attorney’s fees. I authorize HH Physician
Care to release information to insurance carriers and for insurance carriers to release information to HH Physician
Care concerning my illness, treatment and payments (including workmen’s compensation) and I hereby assign to
the physician all payments for medical services rendered to myself or my dependents if assignment applies.

___________________________________________________ ________________________ _______________________
Signature       Date    Time
Date: __________________________
Appointment with: __________________________

Name: _____________________________________________ Date of birth: _____________ Age: ____________

What other doctors/specialists do you see? Name/Specialty: _____________________________________________
_____________________________________________________________________________________________________

Reason for visit: ___________________________________________________________________________________

Any new or worsening problems? If yes, please describe: ____________________________________________________
_____________________________________________________________________________________________________

☐ AIDS/HIV  ☐ Asthma  ☐ Atrial Fibrillation  ☐ Anemia  ☐ Anxiety  ☐ Autoimmune Disease (Lupus)  ☐ Biliary Cirrhosis
☐ Bipolar Disorder  ☐ Blood Transfusion  ☐ Brain Tumor  ☐ Cirrhosis  ☐ CVA/Stroke  ☐ COPD (Lung Disease)  ☐ Colon Cancer
☐ Coronary Heart Disease  ☐ Crohn's Disease  ☐ Chronic Kidney Disease  ☐ Depression  ☐ Diabetes - Type 1
☐ Diabetes - Type 2  ☐ Diverticulitis  ☐ DVT (Blood Clot in Legs)  ☐ Eczema  ☐ Gl Bleed  ☐ Gerd (Acid Reflux)
☐ Hemochromatosis  ☐ High Blood Pressure  ☐ High Cholesterol  ☐ Hypothyroidism  ☐ Hyperthyroidism  ☐ Goiter
☐ Hepatitis A  ☐ Hepatitis B  ☐ Hepatitis C  ☐ Infertility  ☐ Insomnia  ☐ Kidney Stones  ☐ Liver Disease
☐ Lung Cancer  ☐ MI (Heart Attack)  ☐ Migraine Headaches  ☐ Neurological Disorder  ☐ Osteoarthritis
☐ Osteoporosis  ☐ PVD  ☐ PUD (Stomach Ulcers)  ☐ Rheumatoid Arthritis  ☐ Seizure Disorder  ☐ Thyroid Nodule
☐ Tuberculosis  ☐ Valvular Heart Disease  ☐ UTI - Recurrent  ☐ Varicose Veins/Phlebitis  ☐ Abnormal Pap Smear
☐ Breast Disease  ☐ Breast Cancer  ☐ Cervical Cancer  ☐ Gestational Diabetes  ☐ Rh Sensitized
☐ Sleep Apnea  Using a CPAP?  Yes / No

☐ Amputation  ☐ AV Fistula Creation  ☐ AV Graft  ☐ Aortic Valve Replacement  ☐ Aortic Valve Replaced
☐ Appendectomy  ☐ Both Legs Bypassed  ☐ Back Surgery  ☐ Bronchoscopy (Lung Scope)  ☐ CABG (Heart Bypass)
☐ Carotid Endarterectomy  ☐ Carpal Tunnel Right / Left  ☐ Cataract Extraction  ☐ Colon Resection
☐ Craniotomy  ☐ Gastric Bypass  ☐ Gallbladder Removed  ☐ Hemorrhoidectomy  ☐ Hip Replacement Right / Left
☐ Invasive Pain Procedure  ☐ Kidney Transplant Right / Left  ☐ Knee Arthroscopy Right / Left  ☐ Knee Replacement Right / Left
☐ Kyphoplasty  ☐ Mitral Valve Replaced  ☐ Nephrectomy Right / Left  ☐ Pacemaker Implanted
☐ Parathyroidectomy  ☐ Pneumonectomy Right / Left  ☐ PTCA (Angioplasty)  ☐ Rotator Cuff Repair Right / Left
☐ Abdominal Hysterectomy  ☐ Ovaries Removed Yes / No  ☐ Prostate Surgery  ☐ Shoulder Surgery Right / Left
☐ Sleep Apnea Surgery  ☐ Thyroid Surgery  ☐ Tonsil's Removed  ☐ Vascular Surgery  ☐ Breast Augmentation Right / Left
☐ Mastectomy Right / Left  ☐ Lumpectomy Right / Left

Other________________________________________________________________________________________________

PAST MEDICAL HISTORY (Please check if you have any of the below.)

PAST SURGICAL HISTORY

Other________________________________________________________________________________________________

MEDICAL HISTORY WORK-UP SHEET
**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart Artery Disease/Heart Attack</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kidney Disease (Chronic)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Arthritis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Thyroid Disorder</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cancer (Type)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**SOCIAL HISTORY** (Check or circle appropriate)

- Married ☐ Single ☐ Divorced ☐ Widowed
- Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled 
- Occupation: ____________________________
- Children: Yes / No 
- Religious Affiliation: ____________________________

**ALLERGIES OR MEDICATION REACTIONS**

- Allergic to: ____________________________
- Reaction: ____________________________

**RISK FACTORS** (Check or circle appropriate)

- Current tobacco use Year started _________
- Type of tobacco: Cigarettes / Cigars / Snuff / Vapor
- Former tobacco use Year quit _________
- Never smoked
- Second hand smoke Yes / No
- Do you wear a seat belt? Yes / No
- Multiple sexual partners? Yes / No
- Caffeine Use Yes / No
- How many drinks per day _________
- Alcohol use Yes / No
- How many per day? _________ Type _________
- Exercise Yes / No
- Times per week _________ Type _________

**CURRENT MEDICATIONS**

- Refer to List ☐ Refer to Bottles ☐

Please include the dose and how often you take the medication. (Skip if you brought a list or bottles)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>How many times per day?</th>
<th>As Needed (PRN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- Pharmacy ______________________________ Phone # __________________ Location ________________________

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian ______________________________ Date _______________
**MEDICAL PROBLEMS**

Have you had any recent or persistent problems with the following?

### General
- □ Weight Gain/Loss
- □ Fever/Chills/Fatigue
- □ Snoring
- □ Sleep Troubles
- □ Depression/Anxiety

### ENT
- □ Allergies
- □ Sinus Congestion
- □ Glasses/Contacts
- □ Blurred Vision
- □ Ringing
- □ Hoarseness
- □ Runny Nose
- □ Hearing Loss
- □ Trouble Swallowing
- □ Neck Lump
- □ Swollen Glands
- □ Earache

### Lungs
- □ Persistent Cough
- □ Cough Up Blood
- □ Shortness of Breath
- □ Wheezing

### Women
- □ Irregular Periods
- □ Pelvic Pain
- □ Nipple Discharge
- □ Lumps In Breasts
- □ Frequent Sweats/Hot Flashes
- □ Vaginal Discharge

### Skin
- □ Rashes
- □ Abnormal moles
- □ Changes in Hair/Hair Loss
- □ Wounds that will not heal

### Heart
- □ Chest Pain
- □ Palpitations
- □ Shortness of Breath
- □ Ankle Swelling

### Neuro
- □ Headache
- □ Head injury
- □ Blackouts/Dizzy
- □ Seizures/Tremors
- □ Memory Loss
- □ Numbness/Tingling
- □ Forgetfulness/Confusion
- □ Abnormal Coordination

### Urinary
- □ Frequency
- □ Trouble starting or stopping urine stream
- □ Blood In Urine
- □ Painful Urination
- □ Urinating at Night
- □ Urine Leakage
- □ Unable to Urinate

### Gastrointestinal
- □ Reflux/GERD
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Bloody/Black Stool
- □ Hemorrhoids
- □ Loss of Appetite
- □ Rectal Bleeding
- □ Abdominal Pain

### Sexual
- □ Problems with sex
- □ Erectile Dysfunction
- □ Painful Intercourse
- □ Decreased Sexual Desire
- □ Blood in Semen

### Musculoskeletal
- □ Joint Pain
- □ Gout
- □ Varicose Veins
- □ Leg Swelling
- □ Back Pain
- □ Joint Stiffness
- □ Muscle Weakness
- □ Muscle Pain
- □ Muscle Cramps

### Gastrointestinal
- □ Reflux/GERD
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Bloody/Black Stool
- □ Hemorrhoids
- □ Loss of Appetite
- □ Rectal Bleeding
- □ Abdominal Pain

### Sexual
- □ Problems with sex
- □ Erectile Dysfunction
- □ Painful Intercourse
- □ Decreased Sexual Desire
- □ Blood in Semen

### Endocrine
- □ Excessive Thirst
- □ Excessive Urination
- □ High Blood Sugars
- □ Heat Intolerance
- □ Cold Intolerance

Please enter the most recent date and results of the following:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Results</th>
<th>Performed by (who/where)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap Smear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Density Scan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual Period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSA (Prostate Screen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When was your last vaccine on the following:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Would you like one?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Tetanus Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>Shingles Vaccine</td>
<td></td>
<td>Yes / No</td>
</tr>
</tbody>
</table>

Patient name: ________________________________  DOB ____________________
I authorize the use or disclosure of the above named individual’s health information as described below:

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
  - All/entire record
  - Consultation report
  - Visit/encounter notes
  - Operative report
  - Laboratory results
  - Immunization record
  - X-ray and imaging reports
  - Drug and alcohol treatment
  - Problem list
  - HIV/AIDS/STD treatment
  - Medication list
  - Registration record
  - Allergies list
  - Other: ________________________
  - Consultation report
  - Operative report
  - Immunization record
  - Drug and alcohol treatment
  - HIV/AIDS/STD treatment
  - Registration record
  - Other: ________________________
- Records release format:
  - e-delivery
  - (HealthPort connect)
  - CD
  - Paper
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:
  - Name: __________________________________ Address: ____________________________________________
  - for the purpose of: _______________________________________________________________________
- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:
  - ______________________________________________________________________________________
  - If left blank, this authorization will expire six months from the date of signing.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

Signature __________________________________ Date __________________________ Time __________________________

Relationship to patient (if signed by legal representative)

Signature of witness __________________________________ Date __________________________ Time __________________________
Name of Organization/Person
Address
Fax/Phone

Huntsville Hospital requests information for the following patient:

Patient Name
SS# (Optional)          Date of Birth
Address
Phone
Signature              Date of Service

Patient Number: ___________________________

Requested information for treatment, payment or operations:

☐ Discharge summary    ☐ EKG report
☐ History and physical ☐ Nurses’ notes
☐ Operative note       ☐ Progress notes
☐ Pathology report     ☐ Physicians’ orders
☐ Consultation report  ☐ Outpatient record
☐ Emergency dept record ☐ Laboratory results
☐ Labor results
☐ Imaging results
☐ Other: ___________________________

Please send to:

Airport Road  Fayetteville  Madison, Hwy 72
Fax: (256) 265-0777    Fax: (931) 438-0069  Fax: (256) 265-5647
Bailey Cove  Hampton Cove  Madison, Lanier Rd.
Fax: (256) 428-4912    Fax: (256) 265-0357  Fax: (256) 265-5971
Elkton  Lowell Drive  Hazel Green Pediatrics
Fax: (931) 468-2103    Fax: (256) 265-9875  Fax: (256) 828-0526

Signature          Date

_________________________          ___________________________
Relationship to patient          Witness
Patient information

Name: __________________________________________________________ Date of birth: ________________ Date: _____________
Reason for visit: _______________________________________________________________________________________________
Referred by:______________________________________________________ Previous family physician: ________________________

IT IS THE RESPONSIBILITY OF THE PARENTS TO PROVIDE A COPY OF THE IMMUNIZATION RECORD.

Name/s and relationship/s of those living with the child:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
Legal guardian of the child: ________________________________________________________________________________________

Please list the name/s of those who are authorized to bring the child in for medical exams, including immunizations:
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Name/s and phone number/s of those we may discuss the patient’s medical history with (phone and/or office visits):
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

The child’s parents are: □ Married □ Divorced □ Separated □ Unmarried □ Widowed
Is there any legal reason why we cannot discuss the child’s medical care with either parent?
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Education/Development/Social

Does the child attend daycare? □ No □ Yes
What school does the child attend? ____________________________________________ Grade: ______
(If homeschooled, please list)

Does the child receive any special services such as physical therapy, speech therapy, occupational therapy or special education?
□ No □ Yes: _____________________________________________________________________________________________

Does the child have any behavioral, social or learning problems?
□ No □ Yes: _____________________________________________________________________________________________

Does the child participate in organized sports or hobbies?
□ No □ Yes: _____________________________________________________________________________________________

Are there any smokers in the house? □ No □ Yes

Family history

Check any that the child has a family history of from the following:

□ Diabetes □ Seizures □ Sickle Cell Anemia
□ High blood pressure □ Birth defects
□ Childhood heart disease □ Sudden death
□ Asthma □ Other pertinent family medical history:
□ Allergies
□ Learning problems

Medical history

Please list the child’s medical problem and check all that apply.

□ Asthma □ Allergic Rhinitis □ Attention Deficit Disorder (ADD) □ Migraines □ Seizures □ Heart Murmur
Has the child ever been hospitalized? If so, when for what?

☐ No  ☐ Yes: __________________________________________

Has the child ever had any surgeries? Check all that apply.

☐ None  ☐ Appendectomy  ☐ Tonsillectomy  ☐ Adenoidectomy  ☐ Tubes in ears  ☐ Gall Bladder  
☐ Orthopedic  ☐ Other: __________________________________________

What medications does the child take?

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Does the child have any medication allergies?

☐ No  ☐ Yes, list: __________________________________________

Reaction: __________________________________________

What specific health concerns do you wish to address today?

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Do you have any concern about your safety or the child’s safety?  ☐ No  ☐ Yes

For teen girls
Have you started your period?  ☐ No  ☐ Yes, at age: ______  Are your period every month?  ☐ No  ☐ Yes

How long do they last? ____________________________  Are they painful?  ☐ No  ☐ Yes

Have you ever been pregnant?  ☐ No  ☐ Yes

For teen boys and girls
Do you: smoke?  ☐ No  ☐ Yes  Drink alcohol?  ☐ No  ☐ Yes  Use illicit drugs?  ☐ No  ☐ Yes

Are you sexually active?  ☐ No  ☐ Yes - do you practice “safe” sex?  ☐ No  ☐ Yes

Have you ever had a child?  ☐ No  ☐ Yes

What are your long term goals for the future?

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

What talents do you have which give you joy and a sense of accomplishment?

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Dietary history (all ages)
Please list everything the child has eaten or drunk in the last 24 hours:

_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________
_____________________________________________________________________________________________________________

Name of person completing this form: ___________________________  Relationship: ___________________