TN Brain and Spine

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1819 Clinch Avenue • Suite214 • Knoxville, TN 37916
(865) 331-2835 Fax: (865) 331-1003

Patient Name:_____ Arrival Time:_____

Appointment Date:_____ Appt Time: _____

_____Center for Advanced Medicine
1819 Clinch Avenue, Suite 214
Knoxville, TN 37916

_____ Robert F. Thomas
Bldg.744 Middle Creek
Rd. Suite 202
Sevierville, TN 37862

_____ 205 Corporate Place
Alcoa, TN 37701

Thank you for scheduling an appointment. We ask that you complete the attached forms, front and back, and bring them with you to your appointment.

We also ask that if you have had an MRI, CT scan or x-rays taken for the reason you are seeing our physician at a facility other than a Covenant facility, please bring these films and reports with you. **Not doing so will result in having to reschedule our appointment.**

Payment of co-pays and coinsurance is expected at the time of service unless arrangements are made in advance of your appointment. Please contact our patient accounts department at 331-2835 if you anticipate a problem making this payment.

If **you are seeing our physician as the result of an accident please call our office prior to this visit.**

If you need assistance locating our office or have questions regarding your upcoming appointment, please contact our office at 331-2835.

We look forward to seeing you.

** Must arrive on time with paperwork completed*

Covenant Medical Group

Date: _____

Patient Information:

Primary Care Provider:	Provider for Today's Visit:	SSN#:
Name (Last, First, Middle):		Birth Sex: How do you identify, if different than above?
Birth Date:	Age:	Preferred Language:
Veteran (Circle Answer): Yes or No		Ethnicity (Circle Answer): Hispanic or Non-Hispanic
Race (Circle Answer): African American, Alaskan Native, Asian, Hawaiian, Native American Indian, White		Marital Status (Circle Answer): Single, Married, Widowed, Divorced, Legally Separated, Life Partner, Unknown
Mailing Address:		City, State, Zip:
Home Phone:	Cell Phone: Work Phone:	Email Address:
Emergency Contact Name: Relationship to Patient:		Emergency Contact Numbers: Home Phone: Work Phone: Cell Phone:
Referring Physician:		Referring Physician Contact:

If you are a new patient, how did you learn about our office (Circle answer): Direct Mail Family/Friend Internet Ad/Search Newspaper Ad Referral Social Media Other:

If patient is a minor, please fill out this portion:

Parent or Guardian's Name:	Parent/Guardian's Numbers: Home Phone: Cell Phone: Work Phone:

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 (make copies of cards if available, if not, fill in the information below):

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 (Circle): Yes No Date:

Accident (circle answer):

Auto Work Other	Date of Accident:

Registration Staff Signature: _____ Date: _____ Time: _____

Covenant Medical Group

Covenant Medical Group, Inc. ("CMG") Physician Practice Patient Registration Agreement

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question or refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio, video, and other electronic communications), patient portal communications, and by telephone (collectively, "Virtual Services"). **RISKS AND BENEFITS:** Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision-making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. While a patient may expect the anticipated benefits from the use of telehealth, no results can be guaranteed. It is the patient's duty to inform his or her physician of electronic interactions that the patient may have with other health care providers. **CONSENT TO TREATMENT VIA VIRTUAL SERVICES:** By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to

exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is provided at https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. ADVANCE CARE PLAN/HEALTH CARE DECISIONMAKER.

Is the patient providing a copy of an advance care plan to include in the patient's medical record today (e.g., living will)?
☐ **Yes*** ☐ **No**
**If yes, provide patient's health care provider with copy of advance care plan so it can be included in the patient's medical record*

Does the patient want to name a surrogate health care decision maker?
☐ **Yes*** ☐ **No**
**If yes, name of surrogate health care decision maker:* _____ *and relationship to patient:* _____

X. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one:***

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____

Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE and Time _____

Patient Health History

CHIEF COMPLAINT

Patient Name: _____ Date of Birth: _____ Age: _____.

Reason for visit: _____

_____

PAST ILLNESSES: For Example: Hypertension, Diabetes etc.

PAST SURGERIES:		
PROCEDURE	**YEAR**	**SURGEON**

Medication List

please list medications you are currently taking on this sheet

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Telephone: _____

Name of Medications	Exact Dose (mg, mcg, tsp)	How do you take this medication? (ex. 1 tab twice a day)	Who prescribed this medication?

Please list any allergies:

_____

_____

_____

REVIEW OF SYSTEMS

PATIENT NAME:_____ **DATE OF BIRTH:**_____

General:

	Yes	No
Weight Change > 10lbs		
Fever		
Fatigue		
Difficulty Sleeping		

Head and Neck:

	Yes	No
Visual Changes (Not Glasses)		
Dizziness		
Sinus problems		
Frequent persistent nosebleeds		
Ear pain		
Trouble hearing		
Ringing In Ears		
Hoarseness		
Persistent sore throat		
Mouth sores		
Swollen glands (Frequent)		

Respiratory/Lungs:

	Yes	No
Stop breathing during sleep		
Shortness of Breath		
Coughing up blood		
Wheezing		
Cough		
Sore Throat		
Snoring		

Heart/Vascular:

	Yes	No
Chest pain/tightness		
Smothering feeling at night		
Ankle swelling		
Palpitations		
Passing out		

Stomach/Bowel:

	Yes	No
Black/Bloody stools		
Nausea/Vomiting (Frequent)		
Frequent heart burn/acid (GERD)		
Abdominal pain		
Diarrhea (Frequent)		
Constipation		
Difficulty swallowing		

Kidney/Bladder:

UTI	Yes	No
Urinary Incontinence		
Urinary Hesitancy		
Frequent Urination		
Urinary Urgency		
Urinating at night		
Pain with urination		
Blood In urine		

Male:

	Yes	No
Sexual dysfunction		
Infertility		
Painful Intercourse		

Women:

	Yes	No
Breast pain/lumps		
Pelvic pain		
Vaginal discharge		
Vaginal dryness		
Frequent sweats/hot flashes		
Menstrual problems		
Menopause		
Pregnancy Problems		

Skeletal:

	Yes	No
Gout		
Back Pain (Major)		
Neck Pain (Major)		
Weakness of arm or leg		
Joints Swelling/Stiffness		
Deformities of Back/Extremities		

Neuro:

	Yes	No
Numbness or tingling		
Severe frequent headaches		
Abnormal coordination		
Trouble with speech		
Forgetfulness/confusion		

Skin and Hair Problems:

	Yes	No
Changes In hair/hair loss		
Major skin problems		
Wounds that will not heal		
Persistent rash		
Changes in moles		

Psych/Social:

	Yes	No
Anxiety		
Depression		
Insomnia		

_____

Signature /Patient or Legal Representative)

_____

Relationship to Patient *Date*

Patient Name:_____ ***Date of Birth:***_____

Family History

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Mother				
Father				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History

Occupation: _____

Tobacco Use:

- ☐ Never (less than 100 in lifetime)
- ☐ 4 or less cigarettes (less than ¼ pack)/day in the last 30 days
- ☐ 5-9 cigarettes (between ¼ to ½ pack)/day in the last 30 days
- ☐ 10 or more cigarettes (½ 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 the 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
SINUS Products
Other:_____

Packs Per Day:_____

Years Smoked:_____

Alcohol:

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

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

Type:

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

Name:_____ DOB:_____

(PHQ-2) Depression Screening Questionaire

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

Feeling Down, Depressed, Hopeless

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

Little Interest - Pleasure in Activities

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

(PHQ-9) Detailed Depression Screening Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?

3. Trouble falling or staying asleep, or sleeping too much

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

4. Feeling tired or having little energy

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

5. Poor appetite or overeating

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

9. Thoughts that you would be better off dead or hurting yourself in some way

- ○ Not at all
- ○ Several days
- ○ More than half the days
- ○ Nearly every day

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

Fall Risk Assessment

1.Have you fallen in the last year? Yes No

2. Are you worried you might fall? Yes No

3. Do you use a cane or walker? Yes No

4. Do you need someone to help you get up in the morning? Yes No

Have you had a Covid vaccine? Yes No

Local Pharmacy:_____

Pharmacy Phone:_____

Patient Name _____ DOB _____

Prior Special Srvcs/Carrier Resources

Adult Day Care _____
Adult Protective Services _____
Cd Protective Services _____
Clergy _____
Counseling _____
Court Order _____
Department of Child Services _____
Department of Labor (DOL) _____
Development Disability Service _____
DME Vendor _____
Early Childhood Intervention _____
Gifted Program _____
Home & Community Based Service _____
Home Health _____
Hospice Housekeeping _____
Meal Delivery Service _____
Mental Health Services _____
Private Duty Nurse _____
Rehabilitation Services _____
Respite Care _____
Restraining Order _____
Schooling/Home _____
Senior Center _____
Special Education _____
Special Transit _____
Substance Abuse Treatment/Recovery _____
Support Group _____
WIC

Patient's Responsibilities

Caregiver Of Others
Employment
Household Ambulatory Leisure/
Play/Hobbies Medication
Management Parenting
Retired
Social Participation
Student
Caregiver for Pet
Community Mobility
Driving
Financial Management
Health and Wellness
Home Management
Housework
Laundry
Meal Preparation
Personal AOL
Shopping
Volunteer
Yard Work
Other_____

Home Equipment

Bedside Commode _____
BiPAP/CPAP Unit _____
Blood Glucose Monitoring _____
Cane/Large Based Quad _____
Cane/Single Point _____
Cane/Small Based Quad _____
Crutches/ Auxiliary _____
Crutches/Forearm _____
Elastic Laces/Velcro Shoes _____
Enteral Feeding Pump _____
Extended Tub Bench _____
External Defibrillator Vest _____
Grab Bars/Shower _____
Grab Bars/Toilet _____
Hearing Aid _____
Holter Monitor _____
Hospital Bed _____
Infusion Pump _____
Insulin Pump _____
Knee Scooter _____
Lift Chair _____
Motorized Scooter _____
Orthotic/Splint/Brace _____
Ostomy Supplies _____
Oxygen _____
Mechanical Lift _____
Peritoneal Dialysis _____
Prosthesis _____
Shower Chair _____
Suction. Equipment _____
Toilet/Elevated Seat _____
Toilet/Safety Frame _____
Transfer Board _____
Transfer Device _____
Ventilator/Mechanical _____
Ventilator/Mech/Noninvasive _____
Walker/Front Wheeled _____
Walker/Hemi _____
Walker/Rollator _____
Walker/Non-Wheeled Chair _____
Weight Scale _____
Wheelchair/Electric _____
Wheelchair _____
WoundVAC _____
Other_____ _____
_____

Patient Name _____ DOB _____

(1) I Live With

Alone, Independent _____
Alone, Need Assistance _____
Caregiver _____
Family _____
Father _____
Friend _____
Legal Guardian _____
Mother _____
Parent(s) _____
Sibling(s) _____
Significant Other _____
Spouse _____

My Primary Care Giver Is

_____

(2) My Living Situation

Assisted Living _____
Extended Care Facility _____
Group Home _____
Home _____
Homeless _____
Hospice _____
Law Enforcement Detention _____
Nursing Home _____
Psychiatric Unit _____
Rehabilitation Unit _____
Skilled Nursing Facility _____

(3) I Live In

Apartment _____
Facility _____
Hotel/Motel _____
Multilevel home _____
RV Camper/Motor Home _____
Shelter _____
Single Level Home _____
Split Level Home _____
Street _____
Tent _____
Vehicle _____
Unknown _____

Dependent Minor

Are Parents Married y N
Number of Siblings _____

(4) Issues at Home Affecting My Care

None _____
Absence of Family Member _____
Absent Family Member Due To Military _____
Bug Infestation _____
Food Insecurity _____
Inadequate Drinking Water Supply _____
Lack of Insurance _____
Lack of Transportation _____
Narrow Doorways _____
No Air Conditioning _____
No Electricity _____
No Elevator _____
No Heat _____
No Primary Care Physician _____
No Phone _____
No Running Water _____
No Shower/Bathtub on 1st Level _____
Stairs/Outside _____
Stairs/Inside _____
Unable Afford Medications _____
Unemployed _____
Upstairs Bedroom/Bathroom _____

Current Home/Outpatient Treatments

Apnea Monitoring _____
BiPaP/CPAP Dependent _____
Blood Glucose Monitoring _____
Cardio respiratory Monitoring _____
Catheter/Indwelling _____
Catheter/Intermittent _____
Chemotherapy _____
Dialysis/Hernia _____
Dialysis /Peritoneal _____
IV Infusion Therapy _____
Mechanical Ventilation _____
Neutralizer Treatments _____
Oxygen Therapy _____
Radiation Therapy _____
TPN _____
Tube Feeding _____
Wound Care _____

Regular Means of Transportation

Ambulance _____
Bicycle/Scooter/Motorcycle _____
Family/Friends _____
Government Transportation/ETHRA _____
Motorized Wheelchair _____
Public Transport/Bus/Taxi/Uber _____
Private Vehicle _____
Walking _____
Other _____