TMB medical

> your connection to good health

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, Dr. Toby Bond MD, Amanda Stephens NP, Ashley Hardeman NP, Treva Peace NP, medical assistants, and administration staff work closely in a "team approach" to support your patient care.

Our office is open Monday through Thursday from 8:00am-5:00pm, and Friday 8:00am-3:00pm. Every effort is made to see our patients for medical problems during daytime hours. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care.

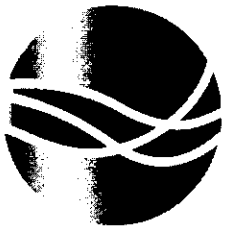
Before you visit, please notify your health insurance company of your new primary care provider if required. Also at the time of your first visit you'll be asked to sign a records request for your previous physician so we can request that a copy of your medical record be sent to us.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. Please bring your health insurance identification card, your covid vaccine card, as well as a photo I.D. Please bring a complete list of all of your medications, as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely, The Providers and staff from TMB Medical

April 2022



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Patient Registration Forms

Patient Information

Patient's Name: (Last, First, Middle) : _____

DOB: _____

Email: _____

Address: _____

City, State, & Zip: _____

SS #: _____

Marital Status: Married ___ Single ___ Divorced ___Widowed ___ Legally Separated ____ Other ___

Contact Information

Home : _____ Cell : _____ Work : _____

Emergency Contact: _____

Phone #:_____ Relationship: _____

How did you hear about us? _____

Preferred Pharmacy: _____

1181 Langford Dr Bldg 200 Ste 105, Watkinsville, GA 30677
Phone: (706) 548-9655
www.tmbmedical.com

Employment Status

Employed ___ Student___ Retired___ Self Employed____ Unemployed____

Employer: _____

Occupation: _____

Employer Address: _____

City, State, & Zip: _____

Responsible Party Information (If different from the Patient)

Name (Last, First, Middle): _____

DOB: _____

Address: _____

City, State, & Zip: _____

SS #:_____

Relationship to Patient: _____

Responsible Party Contact & Employment Info

Home : _____ Cell : _____ Work : _____

Employed ___ Student___ Retired___ Self Employed____ Unemployed____

Employer: _____

Occupation: _____

Employer Address: _____

City, State, & Zip: _____

Primary Insurance Information

Insurance Company Name: _____ Insured Employer Name: _____

Subscriber ID: _____Group ID: _____

CoPay Amount $: _____

Office Policies

- **Scheduling Appointments**
  - Our front office staff may need to question you as to the reasons you need to be seen in order to give you an accurate appointment length. Please answer accurately to help us keep our providers schedules running on time and to minimize wait times.
  - If you are more than 10 minutes late for an appointment, you will be asked to reschedule.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Prescription Refills**
  - We ask that if you get your prescription filled with a pharmacy, **please call your pharmacy first regarding a refill or use the patient portal** with your refill request. (They will contact us)
  - Please allow 3 business days for your prescription requests to be authorized through your provider.
  - If you have an upcoming appointment, that will be the **best time** to discuss refills with your provider.
  - Please **don't** wait until you're out of medication to ask for a refill.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Missed Appointments**
  - Our office does charge a fee for any missed appointments without a phone call or message through our patient portal to cancel at least 24 hours before your scheduled appointment time. If you are charged, this must be paid in full prior to being seen again in our office.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Returned Checks**
  - All returned checks will result in a $30.00 billing fee. The patient will be responsible to pay in full before being seen again in our office.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Lab/Imaging Results**
  - By initialing, you grant us full permission to leave a voicemail with your imaging/lab results. If you have not heard from our office within 1 week of having your labs drawn or imaging done, please call our office.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Zero Tolerance Policy**
  - TMB Medical operates under a **ZERO** Tolerance Policy regarding aggressive/threatening behavior (this includes rudeness) towards any of the TMB Medical Staff, whether face to face or over the phone. Violation of this policy may result in removal from the practice.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Financial Policies**
  - It is the policy of this office to pay for services in full when rendered. If this applies to you, we will file your claim and you will be responsible to pay what your insurance company doesn't pay. In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges. If this account is placed with an attorney for collection, the undersigned parties agree to pay all reasonable attorney fees, as well as costs of collection. I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of the claim.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Privacy Statement**
  - We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. The primacy notice describes our privacy practices, specifically how we use and disclose your medical information and what you have with respect to this information. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices. We are required by the federal law to obtain an acknowledgment from you that you have received this notice. By signing below, you are acknowledging that you have received a copy of or have had access to a copy of the privacy statement.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

- **Photo Authorization**
  - I authorize TMB Medical to use my photo as part of my protected health record for identification and treatment purposes only.

Please Circle One: Self / Parent / Legal Guardian Print Name:_____

Initials_____

HIPPA Privacy Rule

Please list below those who you grant access to your protected health information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996. More information can be found at the U.S Department of Health and Human Services website at hhs.gov.

Name (Last, First, Middle): _____ Phone #:_____

Relationship: _____

Name (Last, First, Middle): _____ Phone #:_____

Relationship: _____

Name (Last, First, Middle): _____ Phone #:_____

Relationship: _____

Name (Last, First, Middle): _____ Phone #:_____

Relationship: _____

Patient Name (Last, First, Middle): _____ DOB:_____

Signature: _____ Date:_____

(Please print name of Legal Guardian or Power of Attorney, if signing, in the space above)

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Patient Health Worksheet

Please complete the following form to help us better understand your medical history and aid us in providing better care for you as our patient.

Name: _____ DOB: _____ Male/Female

Current Medications

Please list all current medications that you are taking. If you need more space, please use the back of this page.

Drug Name	Dosage	Frequency

Allergies

1181 Langford Dr Bldg 200 Ste 105, Watkinsville, GA 30677
Phone: (706) 548-9655
www.tmbmedical.com

Medical History

Please place a check if you have been diagnosed with any of the following conditions.

Cardiovascular		**Hematologic/Oncologic**	
Abnormal Heart Rhythm		Cancer – What type?	
Aortic Aneurysm		Anemia (Low Hemoglobin)	
Abdominal Aortic Aneurysm (AAA)		Thrombocytopenia (Low Platelets)	
Angina		Polycythemia	
Cardiomyopathy		Blood Clotting Disorder	
Congestive Heart Failure		Rheumatologic	
Coronary Artery Disease		Rheumatoid Arthritis	
Heart Attack		Fibromyalgia	
High Blood Pressure		Gout	
High Cholesterol		Polymyalgia	
High Triglycerides		Osteoarthritis	
Peripheral Vascular Disease (PVD)		Lupus	
Deep Vein Thrombosis (DVT)		Psoriatic arthritis (PsA)	
Pulmonary		Ankylosing spondylitis (AS)	
Asthma		**Neurologic**	
Chronic Bronchitis		Seizures or Epilepsy	
Emphysema or COPD		Stroke	
Sleep Apnea		Alzheimer's/Dementia	
Pneumonia		Parkinsons	
Genito-Urinary		**Endocrine**	
Enlarged Prostate (BPH)		Diabetes	
Kidney Stones		High Thyroid	
Chronic Kidney Disease		Low Thyroid	
Chronic UTIs		**Psychiatric**	
Gastro		Depression	
Colon Polyps		Anxiety	
GERD (Heartburn)		ADD/ADHD	
Ulcers		Panic Attacks	
Chronic Diarrhea		Bipolar I/II	
GI Bleed		Schizophrenia	
Musculoskeletal		**Dermatologic**	
Arthritis		Cellulitis	
Spinal Canal or Foraminal Stenosis		Eczema	

Surgical History and Major Hospitalizations

Please list any surgeries and/or major hospitalizations, date of encounter, and hospital.

Date (mm/yyyy)	Surgery/Reason	Hospital

Family History

Please list any pertinent medical conditions within your immediate family. Please note if they are alive or deceased and their age at the time of their passing.

Mother: Alive / Deceased

_____

_____

Father: Alive / Deceased

_____

_____

Paternal Grandfather: Alive / Deceased

_____

_____

Maternal Grandfather: Alive / Deceased

_____

_____

Paternal Grandmother: Alive / Deceased

_____

_____

Maternal Grandmother: Alive / Deceased

_____

_____

Social History

Marital Status: _____ Current Occupation: _____

Work related hazards or chemicals regularly exposed to: _____

Tobacco Use: Nonsmoker / Former Smoker / Current Smoker / Smokeless Tobacco

Length of use or year you stopped: _____ Would you like to quit? Yes / No

Alcohol use: Yes / No If so, how much? _____ How Often? _____ Type? _____

Review of Systems

Please indicate if you currently have any of the following.

Blood Transfusions		Hives/Itching		Bladder Infections	
Changes in Vision		Joint Pain		Constant Runny Nose	
Chest Pain		Muscle Pain		Varicose Veins	
Chicken Pox		Bloody or Black Stool		Skin Disorders	
Dentures		Voice Changes		Recent Stressful Event	
Dizziness		Diarrhea		Sexual Problems	
Ear Infections		Hemorrhoids		Breast Tenderness	
Eye Problems		Heartburn		Bee Sting Reactions	
Fatigue		Shortness of Breath		Bone Pain	
Hearing Problems		Fainting Spells		Enlarged Thyroid	
Painful Intercourse		Wheezing		Poor Circulation	
Recurrent Nose Bleeds		Nervousness		Excessive Sneezing	
Rheumatic Fever		Sleeping Difficulty		Recurrent Bleeding	
Sinus Changes		Memory Loss		Easy Bruising	
Cold Sweats		Hot or Cold Intolerance		Broken Bones	
Watery Eyes		Loss of Bladder Control		Constipation	
Weight Loss		Hot Flashes		Changes in Bowels	
Nausea/Vomiting		Painful Urination		Coughing up Blood	
Muscle Weakness		Heart Murmur		Swallowing Difficulty	
Leg Pain when Walking		Excessive Thirst		Swollen Ankles	
Abdominal Pain		Headaches/Migraines		Gallbladder Problems	
Difficulty Concentrating					

Test & Procedures

Please indicate if you have had any of the following tests or procedures along with the most recent date and the result.

Test	Date	Result	Test	Date	Result
Colonoscopy		Normal/Abnormal	Dental		Normal/Abnormal
Rectal		Normal/Abnormal	Hearing		Normal/Abnormal
Prostate		Normal/Abnormal	Eye		Normal/Abnormal
Papsmear		Normal/Abnormal	Chest X-Ray		Normal/Abnormal
Mammogram		Normal/Abnormal	EKG		Normal/Abnormal
Bone Density		Normal/Abnormal	TB Test		Normal/Abnormal
Blood Work		Normal/Abnormal	Other		Normal/Abnormal