ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

Patient Information Sheet

Patient Information		
Last Name	First Name	Middle Name/Maiden Name
Sex (circle one) Male Female	Date of Birth	Social Security Number
Address	City	State/Zip Code
Home Phone	Cell Phone	Work Phone
Email	Race	Ethnicity (circle one) Hispanic Non-Hispanic
Primary Language	Marital Status	Occupation
Employer	Emergency Contact(s)	Relationship to you
Emergency Contact Phone	Emergency Contact Phone	
Responsible Party		
Name	SS# of Responsible Party	Birth Date of Responsible Party
Address	City, State, Zip Code	Phone Number(s)
Primary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's DOB	Policy Holder's SS#
Secondary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's DOB	Policy Holder's SS#

By signing below, I verify that the above information is correct to the best of my knowledge, and to acknowledge that I have received a copy of Roxboro Family Medicine & Immediate Care P.C.'s Notice of Privacy Practice.

_____ _____ _____

Patient (or Legal Guardian) Signature Date Staff Initials

Health History Questionnaire:

Roxboro Family Medicine & Immediate Care
Not just a clinic, but your medical home

Name_____ Date of birth_____

Taineisha Bolden, MD ~ Liz Buno, MHS, PA-C ~ Terri Cates, MD ~ Eugene Granger, MD ~ Tami Lee, MHS, PA-C ~ Ben Pierce, MHS, PA-C, Noah Wichman, MHS, PA-C

Welcome to our practice! Please take a moment to fill out the following information to help us get to know you and your medical history. This information will be confidential and will only be reviewed by your physician, physician assistant, or nursing staff.

Special Communication Needs:			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐Yes ☐No	Cognitive impairment	☐ Yes ☐No
Hearing impairment	☐ Yes ☐No	Sensory impairment	☐ Yes ☐No
Speech impairment	☐Yes ☐No	Other:	

Personal Health History			
Please check past or current problems or conditions			
Condition		Condition	
☐Hypertension		☐Seizures	
☐High cholesterol		☐Headaches	
☐Diabetes		☐Stroke	
☐Heart attack or angina		☐Prostate problem	
☐Irregular heart rhythm		☐Breast problem	
☐Congestive heart failure		☐Urinary tract infections	
☐Asthma		☐Osteoarthritis	
☐Emphysema or chronic bronchitis		☐Cancer (Please list type)	
☐Pneumonia		☐Thyroid problem	
☐Gastroesophageal reflux disease		☐Bleeding disorder	
☐Stomach ulcer		☐Addiction Issues	
☐Kidney problems		☐Depression or anxiety	
☐Liver disease/hepatitis		☐Mental Illness	
☐Colon cancer		☐Other (please describe)	
☐Bowel/digestive problem			

Previous Surgical Procedures	
Please check if you have had any of the following	
Procedure	Year
☐Heart surgery	
☐Carotid artery surgery	
☐Vascular surgery / stent	
☐Abdominal aneurysm repair	
☐Hysterectomy	
☐Gallbladder removed	
☐Appendix removed	
☐Tonsillectomy	
☐Joint replacement	
☐Breast cancer surgery	
☐Prostate cancer surgery	
☐Hernia	
☐Pacemaker	
☐ Other (please describe)	

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner
Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher
Occupation: Occupational concerns: ☐Stress ☐Hazardous substances ☐Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐Chest pain	☐Rectal bleeding	☐Eye pain	☐Nervousness
☐Shortness of breath	☐Black/tarry stools	☐Loss of vision	☐Pain in testicles
☐Wheezing	☐Weight loss	☐Double vision	☐Loss of libido
☐Cough	☐Weight gain	☐Memory loss	☐Impotence
☐Coughing up blood	☐Loss of appetite	☐Ringing in ears	☐Breast pain
☐Sore throat	☐Difficulty swallowing	☐Pain in ears	☐Breast discharge
☐Nasal congestion	☐Diarrhea	☐Nose bleeds	☐Other (please describe below)
☐Irregular heartbeat	☐Constipation	☐Hoarseness	
☐Fast heartbeat	☐Painful urination	☐Easy bleeding	
☐High blood pressure	☐Blood in urine	☐Easy bruising	
☐Low blood pressure	☐Urine frequency	☐Rash	
☐Lightheadedness	☐Decrease in urine flow	☐Changes in mole	**Females - Please complete**
☐Dizziness/fainting	☐Urine leakage	☐Sore that won't heal	Menstrual flow:
☐Abdominal pain	☐Headache	☐Fatigue/lethargy	☐Reg. ☐Irreg. ☐Pain/cramps
☐Heartburn	☐Weakness	☐Insomnia	Days of flow __ Length of cycle__
☐Indigestion	☐Loss of strength	☐Forgetfulness	1st day of last period_____
☐Ankle swelling	☐Balance problems	☐Depression	☐Pain or bleeding after sex
☐Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
☐Vomiting	☐Arms ☐Hips ☐Back		Miscarriages___
☐Vomiting blood	☐ Legs ☐Neck ☐☐Shoulders		Birth control method _____
☐Change in bowel habits	☐Hands ☐Feet		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
☐Mental illness		☐Chemical dependency	

Allergies:

Please list any allergies to medications or foods

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:				
Please check whether you have had the following preventive services and enter the year of the service				
Immunizations	Year		Tests	Year
Tetanus vaccine / Tdap☐Yes ☐No			Pap smear/pelvic ☐Yes ☐ No	
Pneumonia vaccine ☐ Yes ☐No			Mammogram ☐Yes ☐No	
Influenza vaccine ☐Yes ☐No			Bone dexa☐Yes ☐No	
Shingles vaccine ☐Yes ☐No			Colonoscopy ☐Yes ☐No	
			Prostate test ☐Yes ☐No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐Eye doctor	☐Nephrologist
☐Cardiologist	☐Psychiatrist
☐Oncologist	☐Allergist
☐Urologist / Gynecologist	☐Vascular
☐Gastroenterologist	☐Pulmonologist
☐Endocrinologist	☐Other

Health Behaviors:	
Tobacco use: ☐Never ☐Quit (when)_____ ☐Current smoker	
If current smoker how many packs per day for how many years_____	
Alcohol intake: ☐No ☐Yes If yes how many drinks/how often_____	
Illicit drug use (including marijuana, cocaine, steroids): ☐Never ☐Past ☐Current	
If past or current drug use describe:	
Exposure to secondhand smoke ☐Yes ☐No	Wear a seatbelt ☐Yes ☐No
Eat a diet high in fruits and vegetables ☐Yes ☐No	See a dentist at least once a year ☐Yes ☐No
Get 30 minutes of exercise 5 times a week ☐Yes ☐No	Wear sunscreen ☐Yes ☐No

Advance Care Planning:
Do currently have, or would you like information on, any of the following items
Living Will: ☐ Have☐ Don't Have☐ Want Information
Durable Power of Attorney: ☐ Have☐ Don't Have☐ Want Information
DNR Order:☐ Have☐ Don't Have☐ Want Information
Other:☐ Have☐ Don't Have☐ Want Information

Urinary Incontinence Assessment

Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐	☐	☐	☐
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐
Have you experienced a pressing or immediate urge to urinate?	☐	☐	☐	☐
Have you noticed a change in your urination frequency?	☐	☐	☐	☐
Do you need to urinate more than 8 times every 24 hours?	☐	☐	☐	☐
Do you have to get up more than twice during the night to urinate?	☐	☐	☐	☐
Do you sometimes have to strain to urinate?	☐	☐	☐	☐

Fall Risk Screening

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies and Arbitration Agreement.

Financial Policy

--Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, checks, Visa, MasterCard, American Express, and Discover.

--Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the provider (if you agree to have the insurance company pay the provider directly). If your insurance company does not pay the practice within a reasonable period, we will have to ask you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

--We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay your co-payment at the time of your visit.

--If you are insured by a plan with which we do not have prior arrangements, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send payment directly to you. Therefore, our charges for your care are due at the time of service.

--Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice's financial policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended by the practice at any time.

_____

Patient Signature (or responsible party) (Relationship to patient, if applicable) Date

In accordance with the terms of the United States Arbitration Act, I agree that any dispute arising out of or related to the provision of health care services to me by Roxboro Family Medicine & Immediate Care, PC, shall be subject to final and binding resolution, exclusively through Health Care Claim Settlement Procedures of the American Arbitration Association. I understand that this agreement includes all health care which previously has been or will in the future be provided to me and that this agreement is not restricted to those health care services rendered in connection with this admission or visit. I understand that this agreement also is binding on any individual or entity claiming by or through my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services.

_____

Patient Signature (or responsible party) (Relationship to patient, if applicable) Date

Please print Patient's name: _____

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

RALEIGH DURHAM MEDICAL GROUP, PA

PATIENT REGISTRATION FORM: DISCLOSURES AND CONSENTS

Patient Name:_____ DOB:_____

Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Raleigh Durham Medical Group, PA or the physician/provider individually for services rendered to my dependents or me by the physician/provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Raleigh Durham Medical Group, PA is unable to collect from my insurance carrier for whatever reason.

Medicare/Medicaid/Champus Insurance Benefits: I certify that the information given by me in applying for payment under these programs is correct. I hereby direct that payment of my dependent's or my authorized benefits be made directly to Raleigh Durham Medical Group, PA or the physician/provider on my behalf.

Authorization to release non-public personal information: I certify that I have received and read a copy of the Raleigh Durham Medical Group, PA Patient Information Privacy Policy. I hereby authorize Raleigh Durham Medical Group, PA to the physician/provider individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to mail, call, or email: I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a Raleigh Durham Medical Group, PA representative or my physician/provider to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminds, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Raleigh Durham Medical Group, PA to that effect in writing.

Lab/X-ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment: I hereby consent to evaluation, testing, and treatment as directed by my RDMG physician/provider or his/her designee.

_____

Patient Signature (or Guarantor) (Relationship to patient, if applicable) Date

Please print Patient's/Guarantor's name:

_____

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

Patient Name:_____ Phone:_____

Address:_____DOB:_____

PATIENT PRIVACY DIRECTIVES

In our efforts to comply with HIPAA (Health Insurance Portability and Accountability Act), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and coworkers. You must inform us **in writing** of any changes in your directives.

PARENTS: list all individuals you authorize to bring your children (under 18) in for treatment.

_____ _____

Who can our office discuss your medical information with? Please list their name & number below.

_____ _____

Please provide the name/phone numbers of people that we may talk with/leave messages with regarding appointments:

_____ _____

Please provide the name/phone numbers of people that we may talk with/leave messages with regarding medical treatments and test results:

_____ _____

Please provide the name/phone numbers of people that we may talk with/leave messages with regarding billing and insurance issues:

_____ _____

Cell number that we may text health information to: _____

Emergency Contact:_____Phone:_____Relationship:_____

I acknowledge that I have received a copy of the "Notice of Privacy Practices" **and** that everything above is accurate.

Patient/Legal Representative Signature Printed Name Date Staff Signature:

_____ _____ _____ _____

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

Roxboro Family Medicine & Immediate Care, PC

107 Weeks Drive * Roxboro, North Carolina 27573

Phone: (336) 598-5480 * Fax: (336) 598-5482

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Roxboro Family Medicine & Immediate Care

OR:

_____

_____

Phone: _____ Fax: _____

To use or disclose to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The protected health information of:

Patient Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Treatment Dates/Type of Service: _____

Information to be Disclosed (please check information requested):

( ) Entire medical record (if checked, everything except Psychotherapy will be included)

( ) Face sheet	( ) Consultations	( ) Medication/graphic sheets
( ) Pathology report	( ) X-ray reports/films	( ) Discharge summaries
( ) Physician orders	( ) Progress notes	( ) History and physical
( ) Emergency Dep't notes	( ) Operative/procedure notes	
( ) Lab reports	( ) Nursing notes	( ) Other

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

I acknowledge that the data released MAY INCLUDE material that is protected by law. My initials on the lines below authorize the release (if applicable) of information pertaining to:

( ) Mental health ( ) Drug/alcohol use/testing ( ) Genetic testing

( ) HIV/AIDS and other communicable diseases

The purpose of the use or disclosure is:

( ) Attorney/legal ( ) Continued patient care ( ) Social services/disability

( ) Personal use ( ) Insurance ( ) Other: _____

I understand that:

--I may revoke this authorization at any time.

--The revocation will not apply to information that has already been released in response to this authorization.

--The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

--If I revoke this authorization, I must do so **in writing**.

--The procedure for revoking this authorization is to present my **written** revocation to the health information management department.

--I may refuse to sign this authorization.

--Roxboro Family Medicine & Immediate Care, PC will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal medical privacy law. I understand that a fee may be charged for copying the protected health information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date/event/condition, this authorization will expire automatically in ninety (90) days from the date of signature.

_____

Patient Signature (or authorized representative) Date

Witness Signature:_____ Date _____

Explain the representative's authority to act on behalf of the patient:_____

Date completed:_____ **By:** _____ **Total pages:**_____ **Sent via:**

( )Mail ( ) Courier ( ) Certified Mail ( ) Faxed to #: _____ **( ) Pick up ( ) ID checked**