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

ROXBORO FAMILY MEDICINE & IMMEDIATE CARE, P.C.

Review of Systems: In the past **TWO WEEKS**, have you experienced:

GENERAL	Yes	No	RESPIRATORY	Yes	No	NEUROLOGICAL	Yes	No
Fever			Cough			Headaches		
Chills			Shortness of Breath			Seizures		
Sweats			Wheezing			Weakness		
Weight Gain			**GASTROINTESTINAL**	**Yes**	**No**	Numbness		
Weight Loss			Nausea			**PSYCHOLOGICAL**	**Yes**	**No**
Trouble Sleeping			Vomiting			Depression		
EYES (R, L, Both)	**Yes**	**No**	Diarrhea			Anxiety		
Vision Changes			Abdominal Pain			**ENDOCRINE**	**Yes**	**No**
Eye Irritation			Bloody Stools			Cold Intolerance		
EARS (R, L, Both)	**Yes**	**No**	Constipation			Heat Intolerance		
Hearing Loss			**GENITOURINARY**	**Yes**	**No**	Excessive Thirst		
Earache			Pain with Urination			Excessive Urination		
Ringing			Frequent Urination			**HEMATOLOGICAL**	**Yes**	**No**
NOSE	**Yes**	**No**	Difficulty Starting or Maintaining Urination			Abnormal Bruising		
Nasal Congestion			Sexual Difficulties			Abnormal Bleeding		
Sinus Problems			Incontinence			**SKIN**	**Yes**	**No**
Seasonal Allergies			Nighttime Urination			Rash		
MOUTH/THROAT	**Yes**	**No**	**MUSCULOSKELETAL**	**Yes**	**No**	Itching		
Trouble Swallowing			Muscle Cramps/Aches			Suspicious Lesions		
Hoarseness			Joint Pain/Swelling					
Sore Throat			Back Pain					
CARDIOVASCULAR	**Yes**	**No**	**BREASTS**	**Yes**	**No**			
Chest Pain			Lumps or Masses					
Racing/Skipping Heartbeat			Nipple Discharge					
Swelling of Hands/Feet			Tenderness					

OTHER SYMPTOMS: _____

_____ _____ _____

Patient Name Date of Birth Date

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

Pediatric Health History Questionnaire:

Child's name_____ Date of birth_____

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

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐Fever or rash	☐Tobacco use (how much)
☐Group B strep	☐Alcohol use (how much)
☐Sugar in urine / diabetes	☐Street drug use (what type)
☐High blood pressure	☐Medication use (prescription or over-the-counter - list below)
☐Anemia	
☐Infections (if yes what type and how were they treated)	

Family History				
Relationship		Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father's Name				
Mother's Name				
Siblings Names				

Specifically have any of the child's relatives had the following conditions

Condition	Relative	Condition	Relative
☐Diabetes		☐Kidney problems	
☐Cancer		☐Heart disease	
☐Seizures		☐Stroke	
☐Allergies/asthma		☐Anemia	
☐Bleeding problems		☐HIV	
☐High blood pressure		☐Skin problems	
☐Lung disease		☐Chemical dependency	
☐Mental illness		☐Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late How much:		
Type of delivery ☐Vaginal ☐C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
☐Feeding trouble	☐Seizures	☐Fever
☐Excess vomiting	☐Breathing trouble	☐Receive antibiotics
☐Jaundice (yellow skin)	☐Need of oxygen	☐Diarrhea
☐Cyanosis (blueness)	☐Blood transfusion	☐In intensive care unit

Past Medical History		
Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? Please supply immunization records.		
Has your child had any of the following		
☐Chicken pox	☐Wears glasses	☐Asthma
☐Measles	☐Heart murmur	☐Allergies
☐Mumps	☐ Kidney or bladder infection	☐Broken bones
☐Frequent ear infections (>4 year)	☐Bed wetting (>5 years old)	☐Head injury
☐Frequent throat infections (>4 year)	☐Diabetes	☐Seizures
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Has your child ever been on medication regularly? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Allergies	
Please list any allergies to medications or foods	

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency	

Specialty Providers
In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them

Parent 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