CAROLINA FAMILY PRACTICE & SPORTS MEDICINE

PATIENT REGISTRATION AND UPDATE

Date _____ *A#*_____

NAME:_____ DATE OF BIRTH:_____ SEX: MALE FEMALE
Last First MI

PARENT OR RESPONIBLE PARTY (IF PATIENT IS MINOR) NAME:_____

HOME ADDRESS:_____
Street City State Zip

MAILING ADDRESS IF DIFFERENT:_____

REMINDER CALL PHONE#_____ Reminder calls are given 2 days before appointment.

HOME#_____ Messages may be left: Yes / No CELL#_____ Messages may be left: Yes / No

EMPLOYER:_____ WORK#:_____ EXT:_____

EMAIL:_____
This will be used for possible future correspondence. We will not "sell" your information.

SOCIAL SECURITY#_____ (USED FOR BILLING PURPOSES AND IDENTIFICATION ONLY)

MARITAL STATUS: S M D W O

EMERGENCY CONTACT PERSON:_____ RELATIONSHIP:_____ PHONE #_____

Persons authorized to receive information about my healthcare:

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

I acknowledge that this authorization can only be rescinded by my written authorization.

FAMILY PHYSICIAN:_____ REFERRED BY:_____

Please allow receptionist to scan/photocopy your insurance ID card(s)

Primary Insurance:_____	Secondary Insurance:_____
Insurance ID #_____	Insurance ID #_____
Group#_____	Group#_____
Policy Holder's Name:_____	Policy Holder's Name:_____
Policy Holder's DOB_____	Policy Holder's DOB_____
SS #_____	SS#_____
Claims Address _____	Claims Address _____
Phone # _____	Phone # _____

Please if MEDICARE is secondary please let receptionist know. Additional information is required.

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Financial Responsibility and Assignment of Insurance Benefits:
I guarantee payment to Novant Health and its affiliates (Novant Health) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Novant Health for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:
I voluntarily consent to healthcare treatment ('Treatment') from the physicians and staff at this Novant Facility.
I consent to any necessary lab work, including HIV testing. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to as questions and my questions have been answered.

Signature of Patient or Authorized Person: _____ Date/Time _____

Insurance Party of Financial Guarantor (if different from above): _____ Date/Time _____

Would you like information on advance directives? ___ Yes ___ No
(Living Will, Health Care Power of Attorney, Advance Instruction for Mental Health Treatment, Organ Donation)

Acknowledgement of Receipt of Joint Notice of Privacy Practices:
I have received a copy of the Novant Health Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time.
I may obtain a revised copy of the Notice on the Novant Health's website at www.novanthealth.org, by writing to the Privacy Officer, P.O. Box 33549, Charlotte NC 28233, or by requesting one at any Novant Health provider location.

Signature of Patient or Authorized Person: _____ Date/Time _____

For Staff Use Only
__ Patient refused to sign after he/she receive Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.
__ Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer. (Circle One)

Signature of Staff: _____ **Date/Time** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
__ Interpreter Accepted
__ Interpreter Refused

_____
(Name/Number of Person/Services Chosen/Used)

Carolina
FAMILY PRACTICE & SPORTS MEDICINE

Remarkable People. Remarkable Medicine.

Pre-Appointment Questionnaire

Please take a moment to complete this health history questionnaire prior to your first visit with us or before your annual complete physical exam.

Name: _____ **Date of Birth:** _____ **Date of Appointment:** _____

What are you being seen for today? (If you have a new complaint, provide details about signs, symptoms and duration of the problem): _____

_____

_____

Has anything about your health changed since we last saw you?

_____

_____

Review of Systems: Are you experiencing problems in any of the following areas (circle to indicate yes response)?

Constitutional Symptoms: fever weight loss weight gain fatigue night sweats

Eyes: double vision loss of vision blurred vision

Ear, Nose, Throat: sore throat congestion runny nose ear pain ringing in ears

Cardiovascular: chest pain racing heart

Respiratory: coughing wheezing shortness of breath seasonal allergies

Gastrointestinal: nausea vomiting abdominal pain constipation diarrhea blood in stool

Genitourinary: frequency/urgency/pain or blood with urination irregular periods impotence

Skin: Acne rash changing moles sores ulcers

Neurological: headache weakness numbness or tingling falling dizziness

Musculoskeletal: joint pain or swelling muscle weakness muscle aches

Psychiatric: depression anxiety angry thoughts of self harm

Endocrine: excessive thirst intolerance to heat or cold frequent urination hair loss

Hematological: excessive bruising or bleeding enlarged lymph nodes

What medications are you currently taking? Include Over the Counter, Herbs and Supplements

Medication Name | Dose (Mg) | Frequency (Daily/Twice Daily/etc.)

Do you have any drug allergies or adversities or side effects?

Allergen (Drug) | Reaction

Do you have any Seasonal or Environmental Allergies or Sensitivities?:

Allergen | Reaction

Family History: Please indicate who and at what age your family member acquired the disease listed .

Are you adopted? Yes / No

	Mother	Father	Brother (s)	Sister (s)
Age If Living				
Age at Death				
Alcoholism				
Alzheimer's Disease				
Arthritis				
Asthma				
Auto Immune Disease				
Bleeding Problems				
Cancer (if so what type?)				
Clotting Disorder				
Convulsions/Seizures				
Crohn's Disease				
Diabetes				
Depression /Mental Illness				
Drug Abuse				
Headaches				
Heart Disease				
Hepatitis				
High Cholesterol				
HIV/AIDS				
Hypertension (High Blood Pressure)				
Kidney Disease				
Osteoporosis				
Sickle Cell Disease				
Stroke				
Suicide/Accidental Death				
Thyroid Disease				

Social History: Any changes since last visit? If no, move to next section.

What is your marital status?	Married	Single		Divorced/Widowed
How many children do you have?				
What are their names and ages?				
Tobacco Use:	Never			
	Currently	How many Packs/Day		Desire to Quit ?
	Quit?	How many years ago		
Do you Drink Alcohol?	Abstain	Rarely	Often	
	How many drinks per week?			
Do you use illicit drugs?				
Do you drink caffeine?	How many cups per day?			
What is your occupation?				
Do you have any hobbies?				
How would you describe your nutrition?	Excellent	Good	Fair	Poor
Do you Exercise?	What type of Exercise			
	How Often (Days/Hrs Per Week)			
Are you sexually active?	Do you practice Safe Sex/Monogamous?			
Do you have a living will or Advanced Directives?	Would you like more information?			
Do you have any religious or cultural beliefs that may impact your care?				
What is your highest level of education?				

Past Medical History: Any changes since last visit? If no, move to next section:

	Description	Year
Do you wear glasses or contacts?		
What Surgeries have you had?		
Have you been hospitalized?		
What illnesses or diagnoses		
Do you, or have you had?		
(for example: asthma, COPD,		
Diabetes, Heart Disease, Stroke,		
Cancer, high blood pressure, etc)		
Blood Transfusions?		

Health Maintenance Screening:

When was your last tetanus?	
When was your last Tb Test?	
When was your last Flu Shot?	
When was your last cholesterol test?	
If over 50:	
When was your last Pneumonia Shot?	
When was your last colonoscopy?	
When was your last cardiac test (EKG/stress test)?	

If Female:	
When was your last menstrual period?	
When was your last Pap Smear?	
When was your last Mammogram?	
Do you do self breast exams?	
When was your last bone density test?	
How many times have you been Pregnant?	
How many live births?	
If Male	
When was your last PSA?	
When was your last Prostrate Exam	
Do you perform regular self testicular exams?	

Please list your current healthcare providers and their contact information:

	Provider/Practice Name	City/State	Telephone Number (if known)
Cardiologist			
General Surgeon:			
Dentist:			
Endocrinology:			
Orthopaedist:			
ENT:			
Optometrist/Ophthalmologists:			
Obstetrician/Gynecologist:			
Pharmacist:			
Chiropractic:			
Other:			

Please bring the following items with you to your next visit:

Recent lab test results
Immunization records
A copy of your insurance Card
A copy of your advanced directives if available.

Who may we thank for referring you to our office? _____

Thank you for choosing Carolina Family Practice and Sports medicine as your healthcare provider!