Hugh Chatham Memorial Hospital

New Patient Information

Patient Information Sheet

Name: ____
First Middle Maiden Last

Date of Birth: ________/________/________ Social Security #: ________ - ______ - ________

Address: ____
Street City State Zip

Home Phone: (______) ______ - ___________ Work Phone: (______) ______ - ___________

Cell Phone: (______) ______ - ___________ Other Phone: (______) ______ - ___________

Employer: ____

Occupation: ________________________________ Employer Phone: (_____) _____ - _________

Employer Address: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: ______________________________ Spouse's Phone: (______) ______ - ___________

Spouse's Employer: ___________________________ Spouse's D.O.B: ________/________/________

Spouse's Employer Phone: (______) ______ - ___________

Insurance *(BRING CARD):*

Who is your Primary Care Physician?: ____

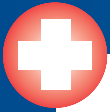
Address: ____

Doctor's Phone: (______) ______ - ___________ Doctor's Fax: (______) ______ - ___________

How did you hear about Hugh Chatham Family Medicine?: ☐ Doctor ☐ Friend ☐ Family ☐ Other

www.HughChathamFamilyMedicine.com

Hugh Chatham Family Medicine



New Patient Information

Name: ____

Date of Birth: ________/________/________ Phone: (______) ______ - ___________

Please note that we do access the North Carolina Controlled Substances Reporting System (CSRS) on a regular basis. *This statewide reporting system was established by North Carolina law to improve the state's ability to identify people who abuse and misuse prescription drugs classified as schedule II-V controlled substances. It is also meant to assist clinicians in identifying and referring for treatment patients misusing controlled substances. The N.C. Commission for, and the Division of, Mental Health, Development Disabilities and Substance Abuse Services make rules and manage the program.*

Hugh Chatham Family Medicine complies and reports the use of controlled substances Reporting System when prescribing controlled substances.

Official Use Only

☐ *Yes* – Next available appointment

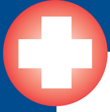
☐ *Yes* – Needs to be seen ASAP

☐ *No* – The individual would be better served staying with their current physician or finding another doctor.

☐ *No* – Other: ____

____

____



New Patient Information

Thank you for considering Hugh Chatham Family Medicine as your primary care provider. **This is NOT an application**, but is a packet of information that must be completed in order for the physician to determine the most appropriate care for you.

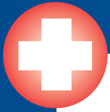
Once your information is received by us, we will review the information and will respond to you within 5-7 business days. At that time we will let you know if our practice can provide services to you as a patient.

This form is for preliminary screening purposes ONLY and is for routine care or non-urgent problems. If you are currently experiencing an urgent problem, you should contact your current personal or primary care doctor or go to your nearest emergency room.

Providing your medical information on this form does NOT create a physician-patient relationship and is not a guarantee of an appointment or of any specific service.

New Patient Information

Please give detailed information regarding your current and long-term health condition.



New Patient Information

Allergies: *(Circle all that apply)*

Codeine Bee Sting Sulfa Penicillin Latex Other: ______________________

Current Medications

Name of Medicine	Dose (mg)	How many times daily?

Do you use **tobacco** in any form? ☐ Yes ☐ No

If yes, please list types used and amount: ______________________

Do you use **alcohol**? ☐ Yes ☐ No

Amount used daily: ______________________

Do you use **illicit** or **street drugs**? ☐ Yes ☐ No

If yes, please list type and frequency: ______________________

Do you consume **caffeine**? ☐ Yes ☐ No

If yes, please describe typical consumption: ______________________

Have you ever been **hospitalized**? ☐ Yes ☐ No

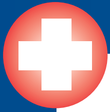
If yes, please list when, where and why: ______________________

____

____

____

____



New Patient Information

Have you ever had a surgical procedure? ☐ Yes ☐ No

When	Where	Type of Procedure

Do you have children? ☐ Yes ☐ No

Name	Date of Birth	Health Problems

Family History:

Please use the code from the list on the right to mark any conditions that you or your family members have been diagnosed ***within the past year***.

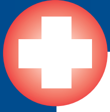
_______ Appendicitis
_______ Prostate Problems
_______ Hysterectomy
_______ Gallbladder Disease
_______ Heart Surgery
_______ Heart Attack
_______ Seizure/Epilepsy
_______ Colon Cancer
_______ High Blood Pressure
_______ Elevated Cholesterol

_______ Diabetes Mellitus
_______ Stomach Ulcers
_______ Stroke
_______ Asthma
_______ Emphysema
_______ Tuberculosis
_______ Lung Cancer
_______ Breast Cancer
_______ Arthritis
_______ Other _______________
____

Y = You
M = Mother
F = Father
S = Sister
B = Brother
S1 = Son
D = Daughter
MGM = Maternal Grandmother
MGF = Maternal Grandfather
PGM = Paternal Grandmother
PGF = Paternal Grandfather

Mother: ☐ Living
☐ Deceased
Cause of Death:____________ Age at Death:_________

Father: ☐ Living
☐ Deceased
Cause of Death:____________ Age at Death:_________



New Patient Information

Emergency Contact Information

1. ____________________ ____________________
Name of person not living with you — Relationship

____________________ ____________________
Address (street, city, state, zip code) — Home/work phone number

2. ____________________ ____________________
Name of person not living with you — Relationship

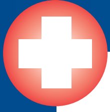
____________________ ____________________
Address (street, city, state, zip code) — Home/work phone number

Authorized Recipient of Information

I hereby authorize Hugh Chatham Family Medicine to discuss my (or my dependent child's) medical information, including lab and x-ray results, appointments, referrals, and medication information with:

____________________ ____________________
Name — Relationship

____________________ ____________________
Signature of responsible party — Date



New Patient Information

Assignment of Benefits

I hereby assign payment directly to Hugh Chatham Family Medicine of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

Release of Information

I hereby authorize Hugh Chatham Family Medicine to release such medical information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Hugh Chatham Family Medicine to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them. If I (or my dependent) is referred to another physician whose practice is owned or operated by Hugh Chatham Memorial Hospital, I herby authorize the release of this patient information packet in its entirety.

Privacy Notice

I acknowledge that I have received the Hugh Chatham Family Medicine Privacy Notice as required by the Health Portability and Accountability Act (HIPAA)

____
Signature of responsible party Date

Insurance Coverage Spouse or Parent

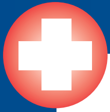
If your insurance coverage is through the employer of your spouse or parent, we must have the policy holder's birth date as well as their social security number in order to file a claim to your insurance company. We apologize for any inconvenience this may cause and appreciate your understanding and compliance with this matter.

Policy Holder's Name: ____

Policy Holder's Social Security Number: ______________________________

Policy Holder's Date of Birth: _____________________________________

____
Signature of responsible party Date



New Patient Information

Authorization for Release of Medical Records

I, ____, do hereby consent and authorize

____

to release to Hugh Chatham Family Medicine all medical records relating to my (or my dependant child's) identity, diagnosis, prognosis and treatment, psychiatric treatment, diagnosis and/or treatment of HIV or related illnesses, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

____

____

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice to Hugh Chatham Family Medicine, except to the extent that any action has already been taken on this release. Otherwise, consent will remain in force for 90 days.

Special Limitation of restrictions, if any: ____

____

________________________ ________________________
Signature of Patient *Date*

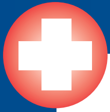
________________________ ________________________
Signature of Witness *Date*

________________________ ________________________
Signature of Parent/Legal Guardian *Date*

Patient's Date of Birth: ________/________/________

Patient's Chart Number: ________________________

Patient's ID: ________________________



New Patient Information

Authorization To Release Information To Family Members

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must complete this form. Signing this form will only give consent to release this information to the family members indicated below. You have a right to revoke this consent in writing.

I authorize/allow Hugh Chatham Family Medicine to release my medical and/or billing information to the following:

1. Name: ______________________ Relation To Patient: ______________
2. Name: ______________________ Relation To Patient: ______________
3. Name: ______________________ Relation To Patient: ______________
4. Name: ______________________ Relation To Patient: ______________

Patient Name ______________________ *Date of Birth* ______________________

Signature of Patient ______________________ *Date* ______________________

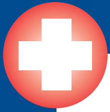
Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern.
At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name ______________________ *Date of Birth* ______________________

Signature of Patient ______________________ *Date* ______________________



New Patient Information

Pre-Consent Form for Treatment of a Minor/Dependant

This pre-consent form allows parents of minors or legal guardians of dependant adults to grant permission for other responsible adults to bring their child or dependant adult to our office for evaluation or treatment.

The undersigned parent/guardian of: ______________________________

Whose date of birth is: ______________________________

Does hereby empower the following named individuals

1. Name: ____________________ Relation To Patient: ____________________
2. Name: ____________________ Relation To Patient: ____________________
3. Name: ____________________ Relation To Patient: ____________________
4. Name: ____________________ Relation To Patient: ____________________

Express permission to act as my agent to consent to and authorize medical evaluation and treatment for my above/ child dependent. This authorization provides authority and power on the part of the above named individuals to give specific consent to any and all such evaluation, diagnosis, office treatment, immunization administration, anesthetic administration, or surgical treatments which a physician, in the exercise of his/her judgement, may deem advisable. This authorization includes hospital admission if such is deemed necessary by the physician.

This authorization shall be valid until or unless revoked by me in writing.

I do hereby indemnify and hold harmless the physicians, staff, an other persons who act in reliance upon this authorization.

Parent/Guardian Name ____________________ *Date of Birth* ____________________

Parent/Guardian Signature ____________________ *Date*____________________