Hugh Chatham Physician Practices

An Affiliate of Hugh Chatham Memorial Hospital

New Patient Packet

Name: _____
Phone Number: (_____)_____
DOB: _____

Office 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:_____

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We are delighted that you have selected us to be your health care provider.

Please take a few moments to review and complete the following forms, which will help us prepare to serve you. Providing this information does not create a physician-patient relationship until an appointment is made and confirmed by our medical office.

After completing the forms, you can either bring them to one of our office or call any of our offices during business hours to arrange to return them by mail, email, or fax. We will review the information provided and contact you within three business days to either schedule an appointment, or to discuss other information that may be needed and next steps.

If you are having symptoms of a health problem that might be urgent, please either contact your current health care provider or go to the nearest urgent care or emergency department.

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Patient Information

Name _____

Date of Birth _____/_____/_____ **Social Security #** _____

Address _____

_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email** _____

Employer_____

Occupation_____ **Employer Phone** _____

Employer Address _____

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

Spouse's Name _____ **Spouse's Phone** _____

Spouse's Employer _____

Spouse's Employer Phone # _____

Insurance (BRING CARD)_____

Who is your current primary care doctor? _____

Address _____

Phone _____ **Fax** _____

How did you hear about our office? **Doctor** **Friend** **Family** **Other**

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Please give a detailed description of your current and long term health condition

Please note that we access the NC Controlled Substance Reporting System (CSRS) on a regular basis when prescribing controlled substances. Please inform us of any treatment you are currently receiving from a pain specialist.

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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 any of these products?

Tobacco __Yes __No
If yes, please describe how much is used daily:
Cigarettes_____
Snuff_____
Chewing Tobacco _____

Illicit or Street Drugs __Yes __No
If yes, please describe:
Type:_____
Amount: _____
Frequency: _____
Have you ever overdosed? __Yes __No

Caffeine __Yes__No
If yes, please describe how much is consumed daily:
Coffee_____
Tea_____
Soft Drinks_____
Other_____

Alcohol __Yes __No
If yes, lease describe how much is consumed daily:
Beer_____
Wine_____
Other_____

Have you ever been hospitalized? ____Yes____No

When	Where	Why

Have you had any surgical procedures? (Circle) Yes No

When	Where	Type of procedure

Do you have children?

Name	Date of Birth	Health Problems

Please use the code in the box below to mark any conditions that you or your family members have been diagnosed with in the past.

_____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= Yourself
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_____

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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**

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Assignment of Benefits

I hereby assign payment directly to Hugh Chatham Family Medicine Elkin 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 Elkin to release such medical and billing 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 Elkin 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 hereby 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 (HIPPA).

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 patient or responsible party Date

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Authorization for Release of Medical Records

I, _____, do hereby consent and authorize

_____

To release to Hugh Chatham Physician Services all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and treatment, psychiatric treatment, diagnosis and/or treatment of HIV related illness, 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 of revocation to Hugh Chatham Physician Services, 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 or 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 _____

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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 the right to revoke this consent in writing.

I authorize/allow Hugh Chatham Physician Services to release my medical and/or billing information to the following individual(s):

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ 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: _____

Patient Signature: _____ Date: _____

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PRECONSENT FORM FOR TREATMENT OF A MINOR/DEPENDENT

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

The undersigned parent/guardian of _____

Whose date of birth is: _____

Does hereby empower and authorize the following named individuals:

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ 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 best judgment, 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, and other persons who act in reliance upon this authorization.

Parent/Guardian Name: _____

Date of Birth: _____

Parent/Guardian Signature: _____

Date: _____