Carolinas Physicians Network
Carolinas HealthCare System
Patient Registration-Adult

ORG# _____

MRN# _____

	Patient	*Parent/Responsible Party- if different* Patient Relationship ☐ Child ☐ Spouse ☐ Other
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact	**Reason for visit** _____
Name		
Home Phone		
Work Phone		Who referred you? _____
Mobile Phone		Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No

	Primary Insurance	**Secondary Insurance**
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician		If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

One patient per authorization form

There may be a charge for record copies.

Carolinas HealthCare System

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request ❑ Other _____

RELEASE FROM: The facility / practice / individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ **Telephone #:** _____

Facility/Practice Address: _____ **Fax #:** _____

The facility / practice / individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): **From:** (MM / DD / YY) _____ **To:** (MM / DD / YY) _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ **All Records & Details**
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab / Pathology Reports
❑ Medication Records
❑ Office / Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology / Imaging Reports
❑ Test Results
❑ Other (Please Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle / Maiden) _____ (Last)

Patient Address: _____ (Street Address / PO Box, City, State, Zip)

Social Security #: _____ **Date of Birth:** _____ **Medical Record/Chart #** _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ **Work:** _____ **Cell:** _____

RELEASE TO: This information may be released to and used by the following individuals / organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals / organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices / Policy.
- This authorization will expire when the information from the event / purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ **DATE:** _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and / or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of of 18, the patient must also sign this authorization.

NAME OF MINOR: _____ **SIGNATURE OF MINOR:** _____ **DATE:** _____

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N / A

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: _____ via ❑ Mail ❑ Fax ❑ Other _____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

_____

Employee Name & Title _____

Employee Signature: _____ Date: _____

Carolinas HealthCare System

Un Paciente Por Formulario de Autorización | Podría Haber un Costo por Copias de Historiales

Carolinas HealthCare System - Authorization for Release of Health Information Form

Carolinas HealthCare System – Formulario de Autorización para Dar a Conocer Información de Salud

Por medio del presente, autorizo el uso o la revelación de mi información de salud identificable como es descrito abajo. Entiendo que si la organización autorizada a recibir la información no es una compañía de seguro o un proveedor de salud, la información entregada podría ya no ser protegida por las regulaciones federales de privacidad.

PROPÓSITO DE LA ENTREGA: ❑Comunicación en Curso ❑Copia del Historial ❑Revisión Legal o del Seguro ❑Solicitación de un Representante Autorizado ❑ Otro _____

ENTREGA POR PARTE DE: La instalación/consultorio/individuo anotado abajo está autorizado a entregar la información de salud solicitada:

Nombre de la instalación/consultorio: _____ Número Telefónico _____

Dirección de la instalación/consultorio: _____ Número de Fax_____

La instalación/consultorio/individuo anotado arriba está autorizado a entregar la información de salud por lo siguiente: fecha(s) del servicio, margen de tiempo o evento(s): Desde:(mes/día/año) _____ Hasta:(mes/día/año) _____

MARQUE LA INFORMACIÓN ESPECÍFICA A SER ENTREGADA:

❑ Todos los Historiales y Detalles	❑ Resumen del Alta	❑ Reportes de Laboratorio/Patología	❑ Notas de Progreso	❑ Ordenes del Doctor
❑ Información de Citas	❑ Historiales de la Sala de Emergencia	❑ Registro de Medicamentos	❑ Evaluación Previa Psiquiátrica	❑ Otros (Por favor, especifíque) _____
❑ Información de Cobros	❑ Historial y Examen Físico	❑ Notas de Oficina/Clínica	❑ Radiología/Reportes de Imágenes	_____
❑ Reporte de la Consulta	❑ Registro de Vacunas	❑ Reporte Operatorio	❑ Resultados de Pruebas	_____

Entiendo que la información en mi historial médico puede incluir información relacionada a tratamiento de abuso de droga o alcohol, anemia de células falciformes, insuficiencia psicológica o psiquiátrica, enfermedades por transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado al SIDA y/o otros virus de la inmunodeficiencia humana (VIH).

NOMBRE DEL PACIENTE CUYA INFORMACIÓN SERÁ ENTREGADA:

Nombre del Paciente: _____ _____ _____
Primer Segundo/De Soltera Apellido

Dirección del Paciente: _____
(Dirección de Calle/Apdo. Postal, Ciudad, Estado, Código Postal)

Número de Seguro Social: _____Fecha de Nacimiento: _____ Número de Historial/Hoja Médica_____

Por favor, provea los números telefónicos donde usted está autorizando a CHS a dejar la información del paciente descrita arriba:

Casa: _____ Trabajo: _____ Celular: _____

ENTREGAR A: Esta información puede ser entregada a y usada por los siguientes individuos/organizaciones. Una autorización aparte debe ser completada si la información entregada o el propósito difieren entre los individuos/organizaciones anotados abajo:

Nombre	Dirección	Número Telefónico/Fax	Parentesco/Relación
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DERECHOS Y FIRMA DEL PACIENTE:

- Entiendo que tengo el derecho de revocar esta autorización en cualquier momento al notificar por escrito al Departamento de Registros Médicos ("Medical Record Department") de la organización mencionada arriba. (Entiendo que la revocación no se aplicará a la información que ya ha sido entregada en respuesta a esta autorización. Entiendo que una revocación no se aplicará a mi compañía de seguro cuando la ley le otorga el derecho de impugnar un reclamo bajo mi póliza.)
- Entiendo que autorizar la revelación de esta información de salud privada es voluntario y puedo rehusarme a firmar esta autorización.
- Entiendo, según el CHS Anuncio de Cómo Manejamos la Privacidad, que puedo solicitar inspeccionar u obtener una copia de la información a ser usada o revelada.
- Esta autorización se vencerá cuando la información del evento/propósito anotado arriba es entregada al destinatario nombrado en este documento.

Si el paciente es menor de edad o es incapaz clínicamente de firmar, un representante autorizado puede firmar esta autorización.

NOMBRE EN LETRA DE IMPRENTA (Paciente/Representante Autorizado): _____

FIRMA: _____ FECHA: _____

Si la firma es de un Representante Autorizado, por favor, indique su parentesco/relación: ❑ Esposo/a ❑ Padre/Madre ❑ Guardián ❑ Testamentario ❑ Apoderado

FIRMA DEL MENOR DE EDAD: Por favor, tome nota, si la información es relacionada al tratamiento de un embarazo, abuso de droga y/o alcohol, enfermedad venérea, o trastorno emocional para un paciente menor de 18 años de edad, el paciente debe también firmar esta autorización.

NOMBRE DEL MENOR: _____FIRMA DEL MENOR: _____ FECHA: _____

COMPENSACIÓN FINANCIERA: Si el solicitante de la información es un proveedor de cuidado de salud, ¿recibirá él alguna compensación financiera a cambio del uso o revelación de la información descrita arriba? ❑ Sí ❑ No ❑ No se aplica

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient / Date of release:_____via ❑Mail ❑Fax ❑Other_____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

CHS Employee Name & Title: _____CHS Employee Signature: _____Date _____

Carolinas Physicians Network

ACKNOWLEDGEMENT FORM

Medical Records # _____

Patient's Name: _____ Date of Birth _____/_____/_____
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:_____ Date: _____
(Patient or Authorized Representative)

Relationship to Patient: _____ Self _____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico _____

Nombre del Paciente _____ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: _____ Fecha: _____
(Paciente o Representante Autorizado)

Relacion al Paciente: _____ Mismo _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar:_____

Cleveland Endocrinology, 510 West King Street, Kings Mtn NC 28086 Phone 980-487-2270 Fax 704-734-0379

Neeraj Ashri MD

Comprehensive Patient History Form

Patient Name: **DOB:** **DOV:** **MR#** **Page for rough notes**

Reason for visit:

Primary Care Physician:
Physician Requesting Consult:
HPI: **(Section for Physician)**

Job# - CP5209
Proof #3 - 3-17-10
FACE Part 1 - Ink: Black
Paper: 20# White Bond
2 part

Please Answer following questions only if You are a Diabetic

How long have you been diagnosed with Diabetes
Number of times checking glucose at home. Frequent low sugar readings Diagnosed with Ketoacidosis
How many days in a week do you
Eat breakfast Eat Lunch Eat Supper Bed Time snack Other Snacks
Have you heard about carb counting… **Yes No** Do you do regular exercise…….. **Yes No**

Please Answer following only if you have Thyroid problem

History of goiter **Yes No** History of Radiation treatment **Yes No** Eye problems due to Thyroid **Yes No**

Please Answer YES OR NO for following only if you have calcium problem

Kidney Stone History of thyroid nodule History of fracture or osteoporosis
Spells of sudden onset sweating, headache, fast heart rate (palpitations)

Please answer YES or NO for following Only if you have adrenal gland problem

Spells of sudden onset sweating, headache, fast heart rate (palpitations)
Rapid weight gain Stretch marks on belly Increased facial or body hair
Low or high Potassium High or low blood pressure Dizziness

Cleveland Endocrinology, 510 West King Street, Kings Mtn NC 28086 Phone 980-487-2270 Fax 704-734-0379

Patient Name: **DOB:** **DOV:** **MR#**

ROS

Have you had any of the following during the past three months? PLEASE ANSWER ALL QUESTIONS

- **CONSTITUTIONAL**

Loss of appetite…… Yes No
Weight loss in last 6 months Yes No
If yes how much
Weight gain in last 6 months Yes No
If yes how much
Fever or chills …….. Yes No
Fatigue …….. Yes No

- **EYES**

Wear glasses/contact lens…….. Yes No
Blurred/ Double vision…… Yes No
Glaucoma……... Yes No
Cataract……. Yes No

- **ENT**

Hearing loss……... Yes No
Ringing in the ears……. Yes No
Earaches or drainage…….. Yes No
Nose bleeds…… Yes No
Bleeding gums…… Yes No
Sore throat or voice change…… Yes No

- **CARDIOVASCULAR**

Chest pain…….. Yes No
Sudden heart beat changes…….. Yes No
Swelling of feet, ankles or hands…… Yes No
Do you have to stop walking due to pain in calf Yes No

- **RESPIRATORY**

Frequent coughing……... Yes No
Spitting up of phlegm…… Yes No
Spitting up blood……. Yes No
Shortness of breath…….. Yes No
Wheezing…… Yes No

- **GASTROINTESTINAL**

Nausea or vomiting……. Yes No
Frequent diarrhea…….. Yes No
Frequent constipation…….. Yes No
Stomach pain…… Yes No
Blood in stool…….. Yes No
Dark Black Stool……. Yes No
Liver problems or Hepatitis ……. Yes No

- **MUSCULOSKELETAL**

Back pain …… Yes No
Back Surgery …….. Yes No
Joint pain/ stiffness/ swelling……. Yes No
Muscle pain or cramps…… Yes No
Do you follow with pain clinic/Rheumatologist. Yes No

- **PSYCHIATRIC**

Sleep problems……. Yes No
Memory loss or confusion…… Yes No
Nervousness…….. Yes No
Depression…….. Yes No
Suicidal Ideation …….. Yes No
Hallucination …….. Yes No
If Yes to any of above, any visit with Psychiatrist Yes No

- **GENITOURINARY**

Frequent urination…… Yes No
Burning or painful urination…… Yes No
Blood in urine…….. Yes No
Incontinence …….. Yes No
Straining or dribbling with urination…… Yes No
Sexual difficulty…….. Yes No
If yes do you want to discuss further …… Yes No

Male

Testicle pain or swelling …… Yes No
Prostate problems ---------- Yes No

Female:

If hysterectomy or post menopausal pl. go to skin section
Are you currently Pregnant ……. Yes No

If not

Irregular periods…….. Yes No
Pain with periods……. Yes No
Vaginal discharge…… Yes No

- **SKIN**

Rash or itching……. Yes No
Change in moles …… Yes No
Change in hair or nails……. Yes No
Follow with Skin specialist…….. Yes No

- **NEUROLOGICAL**

Frequent or recurring headaches……... Yes No
Light headed or dizzy……... Yes No
Numbness or tingling sensations…….. Yes No
Tremors…… Yes No

- **ENDOCRINE**

Glandular or hormone problem…… Yes No
Diabetes…… Yes No
Excessive thirst …… Yes No
Heat Intolerance…….. Yes No
Cold intolerance…… Yes No

- **HEMATOLOGIC/LYMPHATIC/ONCOLOGY**

Slow to heal after cuts……. Yes No
Easily bruise or bleed…….. Yes No
Anemia in last 5 years..……. Yes No
Breast pain/ Lump/ Discharge ……. Yes No

- **ALLERGIC/IMMUNOLOGIC**

History of Rheumatoid arthritis……. Yes No
History of Lupus …….. Yes No
Seasonal Allergies …….. Yes No
Food Allergies…….. Yes No
Any other immunological condition …….. Yes No
Drug Allergies:_____
_____

Signature: Patient_____

Physician _____Date:_____

Cleveland Endocrinology, 510 West King Street, Kings Mtn NC 28086 Phone 980-487-2270 Fax 704-734-0379

Comprehensive Patient History Form

Patient Name: **DOB:** **DOV:** **MR#**

Past Medical, Social, Family History

Please check (√) all that applies to you.

	Yes	No		Yes	No
Diabetes			**If Diabetic please answer following**		
High blood pressure (HTN)			Nerve damage (Neuropathy)		
High cholesterol (Dyslipidemia)			Diabetic Kidney Disease if any		
Kidney Failure (Renal failure)			Do you follow with kidney specialist		
Dialysis			Diabetic Eye Disease (Retinopathy)		
Chronic bronchitis, Emphysema (COPD)			If Yes for Retinopathy, any laser or surgery		
Asthma			Last Diabetic Eye Examination, if any		
Sleep Apnea			Diabetic foot ulcer or amputation		
Cirrhosis (liver)			Do you follow with a foot specialist		
Convulsions (Seizures)			Early fullness after eating (Gastroparesis)		
Stroke					
Enlarged Thyroid (Goiter)					
Underactive thyroid (Hypothyroidism)					
Overactive Thyroid (Hyperthyroidism)					
Circulation problems leg (PAD)					
Erection problems males (ED)					
Osteoporosis					
Kidney Stone					
Congestive Heart Failure			Osteoarthritis		
Heart Attack or Angina (CAD)			Major Depression, bipolar or Anxiety		
Stress test or Cardiac Cath, if any			Heart Burn (GERD)		
Irregular Heart Rate (A Fib)			Stomach ulcer or Bleeding (PUD)		

List previous Surgeries/Serious Injuries		**When?**	
Heart Bypass (CABG) or valve replacement			
Appendix (Appendectomy)			
Uterus with or without Ovaries (Hysterectomy)			
Gall Bladder (Cholecystectomy)			
Knee/Hip surgery or replacement			
Tonsils (Tonsillectomy)			

Social History: Please circle the response.

Marital Status: Single Married Separated Divorced Widowed **#Children if any**

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: If **YES** # of packs per day Years smoking If **NO** Never Previously but quit _____ years ago

Use of Drugs: Never If yes, Type/Frequency

Family Medical History

Diabetes:…….. Yes No
High blood pressure:…….. Yes No
Breast cancer:…….. Yes No
Thyroid problems:…….. Yes No
Hormonal/calcium Problems Yes No
Other cancers:…….. Yes No
Heart disease before 55 years: Yes No
Stroke:…….. Yes No
Blood clots in leg:…….. Yes No