Carolinas HealthCare System

Riverbend Family Practice

ORG# ____________________

MRN# ____________________

Patient Registration-Adult

	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 ☐ **Mother's Maiden Name** ________	**RACE:** ☐ Black or African American ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Multicultural ☐ Asian ☐ Native American ☐ Other ☐ Unknown ☐ Decline
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
	ETHNIC ORIGIN: ☐ Hispanic ☐ Non-Hispanic ☐ Decline	Preferred Language: ________
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact	How Did You Hear About Us?
Name		☐ Drove by ☐ Yellow Pages
Home Phone		☐ Internet ☐ Direct Mail
Work Phone		☐ Employer ☐ Word of Mouth
Mobile Phone		☐ Insurance Co. ☐ Other ________
		☐ Physician (name) ________

	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 Riverbend Family Practice 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: ____________

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: ____________________ Date: ____________

Carolinas HealthCare System

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 PHYSICIANS 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: ______________________________

CHS-052-2HP (6/13)

Carolinas HealthCare System

HIPAA* Authorization Form

Patient Name: ______________________________ DOB: ______________

Do you agree to share information (lab results, medication requests, appointments, billing information, etc.) with anyone?

- ☐ No, I do not wish to share any information
- ☐ Yes (please fill in additional information)

Contact Name	Contact Number	Relationship	Comments

Signature: ______________________________ Date: ______________

Printed Name (if other than the patient): ______________________________

Relationship: ______________

** Health Insurance Portability and Accountability Act of 1996*

Carolinas HealthCare System

Riverbend Family Practice

Patient History

Today's Date ____________ Chart # ____________ MRN # ____________

Name: ____________ Age: ______ Date of Birth ____________ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: ____________

Spouse/Significant Other Name: ____________ Education: Highest Level Completed ______

Vaccines	Approximate Date
Tetanus	
Flu	
Hep B	
Pneumovax	
MMR	
Chicken pox	
TB skin Test Positive Negative	

Exams	Approximate Date
Last Dental exam	
Last Eye exam	
Last Chest X-ray	
Last Colonoscopy/Sigmoidoscopy	
Last Mammogram	
Last Pap Smear	
Last Physical Exam	
Last Prostate Exam/PSA	
Other ____________	

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease		Rheumatic fever	
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*		Stomach/Intestinal disorders	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*		Gallbladder disorders	
Stroke		Thyroid disorders *(goiter)*	
High Blood Pressure		Gout	
Diabetes		Skin disorders	
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*		Depression or other Mental Illness	
Kidney disorders *(including kidney stones)*		Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Arthritis		Alcohol/Drug abuse	
Blood disorders *(anemia, bleeding disorders, etc.)*		Risk factors for HIV	
High Cholesterol		Migraines/Headaches	
Allergies *(food, seasonal)*		Other ____________	

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Operations:

Year:	Reason:

Specialist:

Hospitalizations:

Year:	Reason:

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

See Reverse Side

INDICATE WHICH APPLY TO YOU

PAST MEDICAL HISTORY	Yes	No
1. Hypertension	☐	☐
2. High Cholesterol	☐	☐
3. Heart Disease	☐	☐
4. Heart Valvular Disease	☐	☐
5. Heart Rhythm Disturbance	☐	☐
6. Depression/Anxiety	☐	☐
7. Substance Abuse (Type)________	☐	☐
8. Bipolar Disorder	☐	☐
9. Suicide Attempts	☐	☐
10. Osteoarthritis	☐	☐
11. Peripheral Vascular Disease	☐	☐
12. COPD/Emphysema	☐	☐
13. Asthma	☐	☐
14. Diabetes	☐	☐
15. Thyroid Disease	☐	☐
16. Peptic Ulcer/Reflux	☐	☐

PAST MED. HISTORY (cont.)	Yes	No
17. Ulcerative Colitis/Crohn's	☐	☐
18. Cirrhosis	☐	☐
19. Hepatitis	☐	☐
20. Seizures	☐	☐
21. Migraines	☐	☐
22. Alzheimers/Dementia	☐	☐
23. Rheumatic Disease	☐	☐
24. Fibromyalgia	☐	☐
25. Osteoporosis	☐	☐
26. Sexually Tr. Disease (Type) ____________		
27. Endometriosis	☐	☐
28. Birth Control (Type) ____________		
29. Preg ____ Births _____ Ab/Miscarriage ___		
30. Abnormal Pap	☐	☐
31. Abnormal Mammogram	☐	☐
32. Prostate Disease	☐	☐

PAST MED. HISTORY (cont.)	Yes	No
33. Cancer (Type) ____________	☐	☐
34. Kidney Stones	☐	☐
35. Kidney Failure	☐	☐

PAST SURGICAL HISTORY / SERIOUS INJURIES	Yes	No
1. Appendix	☐	☐
2. Gallbladder	☐	☐
3. Tonsillectomy	☐	☐
4. Blood Transfusions	☐	☐
5. Heart/Vessel Surgery	☐	☐
6. Hysterectomy/Ovaries Removed	☐	☐
7. Hernia Repair	☐	☐
8. Motor Vehicle Accidents	☐	☐
9. Trauma	☐	☐
10. Fractures	☐	☐
11. Missing Organs/Extremities	☐	☐
12. Other ____________________		

GENERAL	Yes	No
1. Fever/night sweats	☐	☐
2. Frequent infections	☐	☐
3. Weight change	☐	☐
4. Appetite/thirst change	☐	☐
5. Excessive fatigue/nervousness	☐	☐
6. Difficulty sleeping	☐	☐
7. Enlarged/tender lymph nodes or glands	☐	☐
8. Other ____________________		

EYES	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Dry eyes	☐	☐
6. Other ____________________		

EARS	Yes	No
1. Hearing loss	☐	☐
2. Earaches	☐	☐
3. Ear drainage	☐	☐
4. Buzzing/ringing	☐	☐
5. Feel "stopped up"	☐	☐
6. Other ____________________		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Hoarseness	☐	☐
5. Changes in taste	☐	☐
6. Sleep apnea *(stop breathing while sleeping)*	☐	☐
7. Other ____________________		

PULMONARY	Yes	No
1. Shortness of breath/difficulty breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Other ____________________		

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other ____________________		

GASTROINTESTINAL	Yes	No
1. Heartburn/indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Black stools	☐	☐
10. Changes in bowel habits	☐	☐
11. Frequent laxatives	☐	☐
12. Liver problems/jaundice/ hepatitis	☐	☐
13. Gallstones	☐	☐
14. Other ____________________		

BREAST	Yes	No
1. Lumps/pain/discharge	☐	☐
2. Other ____________________		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA ______________		
8. Genital concerns	☐	☐
9. Other ____________________		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause/symptoms	☐	☐
7. Problems with pregnancies	☐	☐
8. Sexual difficulties	☐	☐
9. Do you use birth control Type ____________________	☐	☐
10. Date of last pap ______________		
11. History of Abnormal Pap Treatment ______________	☐	☐
12. Date of last mammogram ____________		
13. Age at onset of periods ____________		
14. Frequency of periods ____________		
15. Last menstrual period ____________		
16. Other ____________________		

MUSCULOSKELETAL	Yes	No
1. Joint pain/tenderness	☐	☐
2. Joint swelling/warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Other ____________________		

SKIN	Yes	No
1. Rashes	☐	☐
2. Bruising	☐	☐
3. Mole/lesion changes	☐	☐
4. Skin color changes	☐	☐
5. Skin growths	☐	☐
6. Hair/nail problems	☐	☐
7. Other ____________________		

NEUROLOGIC	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other ____________________		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Phobias	☐	☐
6. Other ____________________		

URINARY	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other ____________________		