Carolinas Physicians Network
Carolinas HealthCare System

# Patient Registration-Adult

ORG# _____

MRN# _____

| | *Patient* | *Parent/Responsible Party- if different*<br>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?<br>☐ 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: _____

Date _____

# Adult Patient History

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 _____

What is the reason for your visit today? _____ Who referred you? _____

| 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** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | **Past hospitalizations/surgeries/serious injuries** ***(including blood transfusions)*** |
| | |
| | |
| | |
| **Birth Control** ***(Oral, Injectable)*** | |
| | |
| | |
| | |
| | |
| | |

| 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**

**One Patient Per Authorization Form**

## Carolinas HealthCare System - CPN Ongoing Communications Authorization for Release of Health Information Form

**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 once it is disclosed.

**PURPOSE OF RELEASE:** ☒ Ongoing Communication regarding your healthcare.

**RELEASE FROM:** The facility/practice/individual listed below is authorized to release the requested health information:
**Facility/Practice Name:** _____ **Telephone #:** _____

**DATES OF SERVICE, RANGE OF TIME OR EVENT(S):** The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s):
From: (MM/DD/YY) Beginning of treatment To: (MM/DD/YY) End of Treatment
This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.

**CHECK THE SPECIFIC INFORMATION TO BE RELEASED:**

☐ All Records & Details ☐ 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 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 inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating.

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 minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

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