Carolinas Physicians Network
Carolinas HealthCare System

# *Specialty* Patient Registration Form

## PATIENT INFORMATION: MRN: ORG MRN:

Patient's Legal Name *(Last, First, Middle)* | Nickname

Social Security Number | Date of Birth | Sex M F | Marital Status ☐ Divorced ☐ Single ☐ Married ☐ Widowed ☐ Separated

Do you have a Primary Care Physician? ☐ Yes ☐ No

Primary Care Physician Name:

Primary Care Physician Address & Phone Number:

Patient Street Address *(Required)* | Home Phone Number

City | State | Zip *(+4 if known)* | Cell Phone Number

P.O. Box | P.O. Box Zip Code | E-Mail Address

Employer Name | Employer Phone Number | Extension

Employer Address *(Street, P.O. Box)* | City | State | Zip Code

Reason for Visit

Referring Physician: | Group Name and/or Address: | Phone#:

**Do we have your permission to leave a voice message (i.e. appointment reminders) at the contact number? ☐ Yes ☐ No**
**Do we have your permission to leave a voice message for normal test results at the contact number? ☐ Yes ☐ No**

## PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL:

☐ *Check Here if Same As Above*

Name *(Last, First, Middle)* | Home Phone Number

Street Address *(Required)* | P.O. Box | P.O. Box Zip Code

City | State | Zip *(+4 if known)* | Social Security Number

Date of Birth | Sex M F | Relationship ☐ Child ☐ Self ☐ Spouse ☐ Other _____

Employer Name | Work Phone Number | Extension

Employer Street Address *(Required)*

City | State | Zip *(+4 if known)*

**How are you paying today?** ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Workman's Comp. ☐ Company Account

## EMERGENCY CONTACT:

Name *(Last, First, Middle)* | Home Phone Number

Street Address *(Required)* | P.O. Box *(if applicable)*

City | State | Zip *(+4 if known)* | Work Phone Number | Extension

Relationship ☐ Child ☐ Spouse ☐ Other _____ | Cell Phone Number



*PLEASE COMPLETE BACK OF FORM*

## INSURANCE INFORMATION:

**Please complete the section below.**

| **Name of Primary Insurance** | | | **Name of Secondary Insurance** | | |
|---|---|---|---|---|---|
| Member/Policyholder (if different from patient): *(Last, First, MI)* | | | Member/Policyholder (if different from patient): *(Last, First, MI)* | | |
| Member/Policyholder ID# | Date of Birth | | Member/Policyholder ID# | Date of Birth | |
| Insurance Co. Phone Number | Group # | | Insurance Co. Phone Number | Group # | |
| Insurance Co. *(Street Address/P.O. Box)* | | | Insurance Co. *(Street Address/P.O. Box)* | | |
| *(City)* | *(State)* | *(Zip Code)* | *(City)* | *(State)* | *(Zip Code)* |

## 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 compliant 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 _____ / _____ / _____

***Office Use Only:***

General Comment Section:

Charlotte Obstetric & Gynecologic Associates
Carolinas HealthCare System

# Medical History Form

Chart # _____

Name _____ (Last / First / Middle Initial) Date _____

Age _____ Birthdate _____ Name you wish to be called _____

What is the main reason for your visit to us? _____

**THE FOLLOWING MEDICAL QUESTIONNAIRE IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE UNLESS YOU AUTHORIZE US TO DO SO.**

## MENSTRUAL HISTORY

Last Menstrual Period (LMP) began _____ Period Prior to LMP began _____

Are your periods regular? ☐ Yes ☐ No Age you started menstruation _____

How often do you menstruate? Every _____ days. How long do your periods last? _____ days.

Cramps are: ☐ Mild ☐ Moderate ☐ Severe ☐ No cramps

Do you have spotting between your periods? ☐ Yes ☐ No Do you have bleeding or spotting after intercourse? ☐ Yes ☐ No

## SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced RELIGION _____

Married *(how long)*: _____ Age of Partner: _____ Health of Partner: _____

Are sexual relations satisfactory? ☐ Yes ☐ No Have you had any previous marriages? ☐ Yes ☐ No If yes, number _____

Number of children by previous marriage _____

Has your present husband had any previous marriages? ☐ Yes ☐ No If yes, number _____

Husband's number of children by previous marriage _____

What are your hobbies or interests? _____

## PREVIOUS OBSTETRICAL HISTORY

Total Number of Pregnancies: _____ Number of Full Term Babies Born: _____ Number of Premature Babies Born: _____

Number of Miscarriages or Abortions: _____ Number of Living Children: _____

| | Delivery Date | Length of Pregnancy | City Where Delivered | Hours of Labor | Baby's Weight | Sex | Newborn Problems |
|---|---|---|---|---|---|---|---|
| 1st Pregnancy | | | | | | | |
| 2nd Pregnancy | | | | | | | |
| 3rd Pregnancy | | | | | | | |
| 4th Pregnancy | | | | | | | |
| 5th Pregnancy | | | | | | | |
| Others | | | | | | | |

Did you ever have the following complications **DURING PREGNANCY?**

High Blood Pressure: ☐ Yes ☐ No Hemorrhage: ☐ Yes ☐ No Cesarean Section. ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No

Kidney Trouble: ☐ Yes ☐ No Convulsions: ☐ Yes ☐ No Anemia: ☐ Yes ☐ No Other: _____

## CONTRACEPTIVE HISTORY

Are you using a birth control method now? ☐ Yes ☐ No Current type: _____ Are you satisfied with this method? ☐ Yes ☐ No

If no, why: _____

Have you ever used:

| | | | |
|---|---|---|---|
| A. Birth Control Pill ☐ Yes ☐ No | When: | Why Stopped: | |
| B. IUD ☐ Yes ☐ No | When: | Why Stopped: | |
| C. Diaphragm ☐ Yes ☐ No | When: | Why Stopped: | |
| D. Rubber Condoms ☐ Yes ☐ No | When: | Why Stopped: | |
| E. Foam ☐ Yes ☐ No | When: | Why Stopped: | |



*(Over, Please)*

## HABITS

Do you smoke or use tobacco? ☐ Yes ☐ No How much? _____

Do you use alcoholic beverages? *(check one)* ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Your present weight _____ Your weight one year ago _____

## PAST MEDICAL HISTORY

| HAVE YOU EVER HAD: | Yes | No | | | Yes | No | |
|---|---|---|---|---|---|---|---|
| 1. High Blood Pressure | ☐ | ☐ | | 16. Sexually Transmitted Dz. *(Syphilis, Gonorrhea, Herpes)* | ☐ | ☐ | |
| 2. Diabetes | ☐ | ☐ | | 17. Infection of Tubes or Ovaries | ☐ | ☐ | |
| 3. Cancer | ☐ | ☐ | | 18. Vaginal Infections | ☐ | ☐ | |
| 4. Heart Trouble or Rheumatic Fever | ☐ | ☐ | | 19. Varicose Veins | ☐ | ☐ | |
| 5. Hepatitis or Jaundice | ☐ | ☐ | | 20. Epilepsy | ☐ | ☐ | |
| 6. Kidney Disease | ☐ | ☐ | | 21. Thyroid Problem | ☐ | ☐ | |
| 7. Bladder Infections | ☐ | ☐ | | 22. Stroke | ☐ | ☐ | |
| 8. Bowel Problem | ☐ | ☐ | | 23. Do you have any Bleeding Tendency | ☐ | ☐ | |
| 9. Asthma or Hay Fever | ☐ | ☐ | | 24. Ulcers | ☐ | ☐ | |
| 10. Migraine Headaches | ☐ | ☐ | | 25. Gall Bladder Trouble | ☐ | ☐ | |
| 11. Pneumonia | ☐ | ☐ | | 26. Thrombophlebitis *(Blood Clots in the Veins)* | ☐ | ☐ | |
| 12. Arthritis or Rheumatism | ☐ | ☐ | | 27. Tuberculosis | ☐ | ☐ | |
| 13. Nervous Breakdown *(or any emotional problem)* | ☐ | ☐ | | 28. Sickle Cell | ☐ | ☐ | |
| 14. German Measles | ☐ | ☐ | | 29. Any other serious illness? | ☐ | ☐ | |
| 15. Anemia | ☐ | ☐ | | 30. Do you wear contact lenses? | ☐ | ☐ | |

## ALLERGIES

| ARE YOU ALLERGIC TO: | Yes | No | REACTION | | Yes | No | REACTION |
|---|---|---|---|---|---|---|---|
| Penicillin | ☐ | ☐ | | Sulfa | ☐ | ☐ | |
| Any Other Drugs *(please name)* | ☐ | ☐ | | Other Allergies *(please name)* | ☐ | ☐ | |
| | ☐ | ☐ | | | ☐ | ☐ | |

## SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

| | Yes | No | Date | Dr. | | Yes | No | Date | Dr. |
|---|---|---|---|---|---|---|---|---|---|
| D & C | ☐ | ☐ | | | Repair of Bladder | ☐ | ☐ | | |
| Conization | ☐ | ☐ | | | Appendectomy | ☐ | ☐ | | |
| Cesarean Section | ☐ | ☐ | | | Tonsillectomy | ☐ | ☐ | | |
| Hysterectomy | ☐ | ☐ | | | Blood Transfusion | ☐ | ☐ | | |
| Removal of Ovaries | ☐ | ☐ | | | Any Other Operation | ☐ | ☐ | | |
| Removal of Tubes | ☐ | ☐ | | | | ☐ | ☐ | | |
| Tubal Ligation | ☐ | ☐ | | | | ☐ | ☐ | | |
| Mastectomy | ☐ | ☐ | | | | ☐ | ☐ | | |

Have you ever had to be put in the hospital for reasons other than childbirth or surgery? ☐ Yes ☐ No

Date: _____ Place: _____ Why? _____

Date: _____ Place: _____ Why? _____

Date: _____ Place: _____ Why? _____

## DRUGS TAKING NOW

| Drug | Yes | No | Name of Drug *(if known)* | How Often? | Drug | Yes | No | Name of Drug *(if known)* | How Often? |
|---|---|---|---|---|---|---|---|---|---|
| Vitamins | | | | | Antihistamines | | | | |
| Aspirin | | | | | Blood Pressure Pills | | | | |
| Laxatives | | | | | Heart Medicine | | | | |
| Hormones | | | | | Cortisone | | | | |
| Antibiotics | | | | | Diuretics | | | | |
| Tranquilizers | | | | | Others | | | | |
| Thyroid | | | | | | | | | |

## FAMILY HISTORY

| Relationship | Age | Health Now | Age at Death | Cause of Death | Relationship | Ages | Health Now | Age at Death | Cause of Death |
|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | |
| Mother | | | | | No. of Brothers | | | | |
| | | | | | No. of Sisters | | | | |

**Has any blood relative *(Parents, Grandparents, Uncles, Aunts, Cousins, Brothers, Sisters, Children)* ever had:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies *(Asthma)* | ☐ Yes | ☐ No | Who? _____ | Stroke | ☐ Yes | ☐ No | Who? _____ |
| Breast Cancer | ☐ Yes | ☐ No | Who? _____ | Multiple Births | ☐ Yes | ☐ No | Who? _____ |
| Colon Cancer | ☐ Yes | ☐ No | Who? _____ | Kidney Disease | ☐ Yes | ☐ No | Who? _____ |
| Other Cancer | ☐ Yes | ☐ No | Who? _____ | Birth Defects | ☐ Yes | ☐ No | Who? _____ |
| Diabetes | ☐ Yes | ☐ No | Who? _____ | Blood Abnormality | ☐ Yes | ☐ No | Who? _____ |
| Heart Trouble | ☐ Yes | ☐ No | Who? _____ | Epilepsy | ☐ Yes | ☐ No | Who? _____ |
| High Blood Pressure | ☐ Yes | ☐ No | Who? _____ | Mental Illness | ☐ Yes | ☐ No | Who? _____ |

# Carolinas Physicians Network
Carolinas HealthCare System

## PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

**TO OUR VALUED PATIENTS:**

**THANK YOU** for choosing Carolinas Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

**FOR YOUR CONVENIENCE** we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

**PAYMENT (such as co-pays, deductibles & co-insurance)** is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

**INSURANCE CARDS must be presented at each visit.** You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

**MEDICARE PLANS** are more numerous and complicated. Carolinas HealthCare System and Carolinas Physicians Network participate with **Traditional Medicare (Part A & Part B)** only. We do not accept any Medicare Advantage managed care plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

**MANAGED CARE PLANS** have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

**COMMERCIAL INSURANCES** are those plans we do not participate in. You will be responsible for payment in full at the time of service. Since we are non-participants in the plan, we do not accept the Usual & Customary fee. As a courtesy, we will file your claim.

**WORKER'S COMPENSATION** may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

**MEDICAID** may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Indentification Card to each visit. These cards are valid for only one month at a time, so it is very important to bring the current month card to your visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

**HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS** are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

**SELF PAY PATIENTS** are those patients who **do not have any insurance coverage**. Self pay patients will be given a 20% discount off the charges for services provided, if the patient pays their bill in full at the time of service. The discount does not apply to billed services. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

**MEDICAL LEAVE/DISABILITY FORMS** will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

**I understand my responsibilities as outlined above and will abide by them.**

Patient/Guardian Name _____

Patient/Guardian
Signature_____ Date_____

# How Did You Hear About Us?

*Thank you for choosing the physician practices of Carolinas Physicians Network. We would appreciate you taking the time to complete this form.*

*Please select one of the following:*

*Did you hear about us in one of the following ways:*

| | |
|---|---|
| Community Seminar/Event | Where/When: _____ |
| Mail | _____ |
| Newspaper Advertisement | Publication: _____ |
| Patient Resource Center Brochure | _____ |
| Radio Advertisement | Station: _____ |
| Saw the Facility | _____ |
| Social Services | _____ |
| Television Advertisement | Station: _____ |
| Web site | _____ |
| Yellow Pages | _____ |
| Other | _____ |

*Whom may we thank for referring you to our practice?*

| | |
|---|---|
| Carolinas HealthCare System Employee | Name: _____ |
| Employer | Name: _____ |
| Friend | Name: _____ |
| Insurance Provider | Name: _____ |
| Physician Referral | Name: _____ |
| Relative | Name: _____ |

Your Name: _____

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