Carolinas HealthCare System

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	Reason for visit _____
Name	
Home Phone	Who referred you? _____
Work Phone	Permission to leave voice mail @ primary phone number?
Mobile Phone	☐ 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: _____

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: _____

North Charlotte Medical Specialists-University
Patient History Form

Name_____Age_____
Date_____

Problems to discuss with Physician/NP today

1)_____3)_____

2)_____4)_____

Medical Problems(check all conditions **you** have & approximate date on onset)

Elevated Blood Pressure_____Asthma_____
Heart Disease_____Diabetes_____
High Cholesterol_____ Cancer_____
Blood Disorder_____Thyroid disorder_____
Other_____

Past Surgeries/Procedures

1)_____3)_____
2)_____4)_____

Family History(Please stipulate relationship to you by listing Mother, Father, Maternal/Paternal Grandmother, Maternal/Paternal Grandfather, Sister, Brother)

Elevated Blood Pressure N Y_____
Asthma N Y_____
Heart Disease N Y_____
Diabetes N Y_____
High Cholesterol N Y_____
Cancer N Y_____
Blood Disorder N Y_____
Thyroid Disorder N Y_____

Other_____

Allergies:_____

Current Medications:

1)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

Social History

Marital Status: Single___ Married___ Divorced___Widowed____

Occupation_____

Tobacco Use: Y N How much per day/month_____
Drink Alcohol: Y N How much per day/month_____
How much caffeinated soda do you drink per day_____
How much caffeinated coffee do you drink per day_____
How much caffeinated tea do you drink per day_____

How many times per week do you exercise_____ Duration_____
Type of exercise walking___ running___ yoga___weights_____
Other_____

North Charlotte Medical Specialists-University
101 W T Harris Blvd
Suite 5002(5000 bldg, ground floor)
Charlotte NC 28262
704-863-9700

Carolinas HealthCare System

North Charlotte Medical Specialists - University

Jennifer Burke, MD
Richard Mitchner, MD
Matthew Moll, MD
Laura Lupton, MD
Nancy Durning, FNP-C

Tina Bostic, Manager

Dear Patient,

Thank you for choosing us for your health maintenance needs. North Charlotte Medical Specialists-University practices comprehensive medicine which includes the preventative health maintenance examination you are scheduled for today. Your complete annual exam/physical will be billed to your insurance carrier as a preventive care service. We will **not** be collecting a copay today, however you may receive a bill from us after your claim is processed.

If you have other issues that you would like addressed today, or you have a chronic medical condition(s) that require follow up care (ie:Diabetes, Hypertension, elevated Cholesterol, or any other non-preventative issue (like a rash or back pain, headaches, etc) **those additional services will not be considered part of your preventive care** benefit by your insurance carrier.
Therefore, if any other services are rendered or discussed today, other than normal routine preventative services, they may not be covered by your insurance carrier which may result in you receiving a bill for an additional copay or co-insurance amount.

You will be responsible for any charges that are not covered by your insurance carrier. It is very important for you to understand your individual benefit coverage prior to your visit today, since all insurance policies are different. Should you have any additional questions about what may be considered a non-preventive service, please ask your physician during your visit today.

Sincerely,

The Physicians & Staff at NCMS-U

Patient's Signature_____ _____Date_____

101 East W.T. Harris Boulevard, Suite 5002 - Charlotte, NC 28262 - 704-863-9700 - 704-863-9701 (fax)

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:_____