PATIENT INFORMATION

DATE: ____________ CHART #: ____________ Social Security #: ____________

Patient Name: ____________ LAST FIRST MIDDLE MAIDEN

Address: ____________ City: ____________ State: ________ Zip: ________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ ext. ______ DOB: ________

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Legal Guardian

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer Name: ____________ Employment Status: ☐ Full-time ☐ Part-time

Employer Address: ____________ City: ____________ State: ________ Zip: ________

Occupation: ____________ Student: ☐ Full-time ☐ Part-time

Parents: (if patient is a minor) Father's Name: ____________ Date of Birth: ________

Mother's Name: ____________ Date of Birth: ________

Referring Physician: ____________

RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN PATIENT

Responsible Party Name: ____________

Address: ____________ City: ____________ State: ________ Zip: ________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ ext. ______ DOB: ________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security #: ____________ Employer Name: ____________

Employer Address: ____________ City: ____________ State: ________ Zip: ________

Occupation: ____________ Employment Status: ☐ Full-time ☐ Part-time

INSURANCE INFORMATION

INSURANCE ONE

Policyholder's Name (as it appears on card): ____________ Policyholder's #: ____________

Name of Plan: ____________ Policy Group #: ____________

Address to Mail Claims: ____________ City: ____________ State: ________ Zip: ________

Phone: ( ) ____________ Effective Date: ____________ Termination Date: ____________

INSURANCE TWO

Policyholder's Name (as it appears on card): ____________ Policyholder's #: ____________

Name of Plan: ____________ Policy Group #: ____________

Address to Mail Claims: ____________ City: ____________ State: ________ Zip: ________

Phone: ( ) ____________ Effective Date: ____________ Termination Date: ____________

INSURANCE THREE

Policyholder's Name (as it appears on card): ____________ Policyholder's #: ____________

Name of Plan: ____________ Policy Group #: ____________

Address to Mail Claims: ____________ City: ____________ State: ________ Zip: ________

Phone: ( ) ____________ Effective Date: ____________ Termination Date: ____________

EMERGENCY CONTACT INFORMATION

Name: ____________

Address: ____________ City: ____________ State: ________ Zip: ________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ ext. ______

Relationship to Patient: ____________

Carolinas Medical Center
NorthEast

AUTHORIZATION FOR TREATMENT: The undersigned hereby applies for outpatient treatment and/or admission of the patient to Carolinas Medical Center-NorthEast and give permission to the physician in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination in this hospital. I understand that students or residents in various health-related training programs may participate in my care or observe special procedures.

RELEASE OF INFORMATION: The undersigned authorizes CMC-NorthEast to disclose all or any parts of the patient's medical record to any of the following: listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning worker's compensation case, any review agency which conducts reviews of hospital utilization under an agreement with the patient's employer or other payment source, and any health care organization, healthcare provider or agency needing medical information to assist in the patient's continuing care. The disclosed medical record may include information regarding the treatment of psychiatric and drug and alcohol abuse conditions, information concerning AIDS, AIDS-related conditions or HIV status. CMC-NorthEast will make every effort to pre-certify and/or pre-authorize treatment with third party payors who conduct Utilization Review as a service to patients; however, CMC-NorthEast does not accept responsibility for lack of pre-certification and/or preauthorization and is not responsible for the final payment outcomes or timing restraints. I further agree to have my name, date of birth, and physician's name posted outside my door and on unit assignment boards for identification purposes. I also understand that I may revoke this authorization by providing written notice to the hospital.

MEDICARE/TRICARE, MEDICAID PATIENT'S INFORMATION: I certify that the information I have given in applying for payment under Title V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I understand that the health care services paid for under Medicare, Medicaid and Maternal and Child Health Programs are subject to review by the Professional Review Organization. I authorize CMC-NorthEast and the applicable County Department of Social Services (e.g., Cabarrus, Mecklenburg, Rowan, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. This information may include the following: date of application, application status, the reason my application remains pending, any verification required to complete my application, the date and reason of denial (if applicable). I have received the document titled "An Important Message from TRICARE" or "Medicare" at the time of my admission. My signature only acknowledges my receipt of this message from CMC-NorthEast and does not waive any of my rights to request a review or make me liable for any payment.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to CMC-NorthEast and all physicians involved in my treatment or diagnosis at CMC-NorthEast by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of hospitalization or Outpatient Services of the below named patient. I unconditionally assign any insurance benefits to CMC-NorthEast and all physicians involved in my treatment and further authorize both to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

INDEPENDENT CONTRACTORS: **I understand that many physicians (and their assistants) providing care at CMC-NorthEast are independent contractors and NOT CMC-NorthEast employees. I consent to care by these non-employees. I understand that I will receive a separate bill for all physician (and assistants) services provided to me.**

PERSONAL VALUABLES: I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

Signature of Patient (or legally authorized representative): Relationship to patient:	Date	Signature of Guarantor (or responsible party): Relationship to patient:	Date
Witness:		Patient is a minor of ______years of age or is unable to sign because: ________________	

TELEPHONE CONSENT FOR TREATMENT

Name/Title of 2 Persons Witnessing Consent: ________________ ________________	Date Time	Person Called: Relationship to patient:
Consent Granted: Yes _____ No _____	Remarks:	

Carolinas Physicians Network
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 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:_____________________________

WEDDINGTON
INTERNAL MEDICINE & PEDIATRICS
An affiliate of NorthEast Medical Center

PATIENT HISTORY

Date ____________

Name ____________ Date of birth ________ Sex M ______ F ______

Occupation ____________ Marital Status Single ______ Married ______

____________ Divorced ______ Widowed ______

Race ____________ Age ________

PAST MEDICAL HISTORY Have you ever had any of the following? (Circle)

Glaucoma	Asthma	Kidney stone	Arthritis
Cataracts	Emphysema	Kidney infections	Low back problems
Sinus troubles	Tuberculosis	Bladder infections	Migraine headaches
Allergies	Pneumonia	Prostate trouble	Seizures
High blood pressure	Stomach ulcers	HIV	Depression
Angina	Hepatitis	Sexually transmitted disease	Anxiety
Heart murmur	Gallstones	Skin cancer	Panic attacks
Stroke	Irritable bowel	High cholesterol	
Phlebitis	Blood trnasfusion	Thyroid problems	
Sickle cell anemia		Diabetes	

Other serious illness: ____________

OPERATIONS (Give date or age)

Tonsils ______	Gallbladder ______	Appendix ______	Hysterectomy ______
Prostate ______	Hernia ______	Heart ______	Breast ______
Vasectomy ______	Tubal ligation ______		

Other ____________

OTHER HOSPITALIZATIONS ____________

____

CURRENT MEDICATIONS: (Give name and does)

1. ____________ 4. ____________

2. ____________ 5. ____________

3. ____________ 6. ____________

ALLERGIES: (Medications, Foods, Pollens, etc.)

____

IMMUNIZATIONS (Approximate date or age)

PPD ________ Pneumonia ________ Tetanus ________ Hepatitis ________

Flu Vaccine ________

FAMILY HISTORY

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children				

HABITS Do you

	Yes	No	Amount/Type
Use tobacco (cigarettes, cigars, chewing tobacco)			
Use alcohol (beer, wine, liquor)			
Use caffeine (coffee, tea, colas)			
Diet (restrictions, special diet)			
Exercise regularly			
Wear seat belts?			

Who lives with you? ____________________

Highest educational level achieved ____________________

FOR WOMEN

Age at first period ____________________ Date of last period ____________________

Regular Periods? Yes _____ No _____ Interval between periods _______ Length of periods _______

Pregnancies _______ Live births _______ Miscarriages _______ Abortions _______ Sill births _______

Birth control method ____________________ Doing monthly self breast exam? ____________________

WHEN DID YOU LAST HAVE THESE PERFORMED?

Cholesterol ____________________ Complete physical ____________________

Stool for blood ____________________

For men: Prostate exam ____________________

For women: Pap smear ____________________ Mammogram ____________________

WHAT ARE YOUR MOST IMPORTANT PROBLEMS OR QUESTIONS TODAY?

____

____

____

____

____

Review Of Systems Questionnaire

Have you been feeling any of these symptoms today?

Patient Name________________________________ **DOB**________

Today's Date:

Constitutional	Yes	No	*	Chest	Yes	No
Feeling tired or poorly			*	Difficulty swallowing		
Fever (as symptom)			*	A cough		
Chills (as symptom)			*	Shortness of breath		
Recent weight loss(lbs)			*	Palpitations		
Recent weight gain(lbs)			*	Chest pain or discomfort		

Ear, Nose, Throat	Yes	No	*	Hemo/Endocrine	Yes	No
Nasal congestion			*	An easy bruising tendency		
Post-nasal drip			*	Excessive sweating		
Sore throat			*	Sweating heavily at night		
Earache (right)			*	Excessive thirst		
Earache (left)			*	Temperature intolerance		

Urinary	Yes	No	*	Neuro/Eyes	Yes	No
Pain during urination			*	Headache		
Increased urination			*	Dizziness		
Blood in urine			*	Ringing in ears		
Urinating more than 1 x night			*	Numbness		
			*	Decrease in strength		
			*	Red Eyes		
			*	Sleep disturbances		
			*	Depression		
			*	Anxiety		

GI	Yes	No	*	Gynecological (women)	Yes	No
Decreased appetite			* *	Unexplained vaginal bleeding		
Abdominal Pain			*	Vaginal discharge		
Nausea			*	Vaginal pain		
Vomiting			*	Vaginal itching or burning		
Diarrhea			*			
Constipation			*			
Heartburn			*			
Blood in stool			*			

Skin/Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		

One patient per authorization form

Carolinas HealthCare System

There may be a charge for record copies.

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

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: ____________