Patient Registration

Patient's Name_____DOB___-___-___
(First) (MI) (Last)

Address _____
(Street) (City) (State) (Zip) (County)

Race: [ ] American Indian [ ] Asian [ ] African American [ ] Caucasian [ ] Native Hawaiian or Pacific Islander [ ] Other [ ] Patient Declined

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Patient Declined Language: [ ] English [ ] Spanish [ ] Other

Home Phone (__)_____Work Phone (__)_____Cell Phone (___)_____

Patient's SS# ___ -___-_____ Financial Responsibility: [ ] Patient [ ] Other_____

Is patient currently working? [ ] Yes [ ] Patient's Employer _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated Spouse's Name_____

Emergency Contact_____Relationship_____Phone_____

PLEASE GIVE THE FRONT DESK YOUR PHOTO ID AND YOUR INSURANCE CARD(S) FOR US TO MAKE A COPY FOR YOUR FILE.

NO SHOW POLICY

A "no show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment time.
A $50 fee will be charged for each "no show."
A pattern of repeated "no shows" for appointments will result in dismissal from this medical practice.
Your signature below indicates that you are aware and understand this policy. Should you have any questions, please direct them to the front office representative.

_____ _____
Signature of patient, if minor, signature of responsible party Date

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Patient Name_____ **Date of Birth**_____

Preferred Contact Method: [ ] Phone [ ] Mail [ ] Email_____

Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health and its physicians and other providers and staff to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Harnett Health provider. I hereby authorize direct payment to Harnett Health of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Harnett Health to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Harnett Health for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health on demand for all such charges. I understand that all co-pays and self pay monies are collected up front before services are rendered.

Signature_____ Date_____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Authorization to Release Information: I hereby authorize Harnett Health to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and /or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Harnett Health to me or the Patient stated above. I also hereby authorize Harnett Health to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature_____ Date_____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Receipt of Notice of Privacy Practices: I understand and have been provided with a Harnett Health' Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Harnett Health reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Harnett Health.

Signature_____ Date_____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

HARNETT HEALTH

Medical History Information

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State ____ Zip _____

Gender: M/F

Pharmacy Name _____ Pharmacy Phone(___)_____

PAST MEDICAL HISTORY

Are you allergic to any medications? ____ No _____ Yes If yes, which ones?

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a history of:

[ ] Asthma
[ ] Lung Disease
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Heart Failure
[ ] Heart Attack
[ ] Heartburn or Reflux
[ ] Cancer (type_____)
[ ] Degenerative Arthritis
[ ]Rheumatoid Arthritis
[ ] Kidney Stones
[ ] Kidney Disease
[ ] Disc Disease
[ ] Tuberculosis
[ ] Gout
[ ] Intestinal Disorder
[ ] Diabetes
[ ] Thyroid problems
[ ] Colitis
[ ] Metabolic Disorder
[ ] Stroke
[ ] Mental Illness
[ ] HIV/ AIDS
[ ] Other
_____

Date of last Physical Exam: _____
Date of Last Colonoscopy: _____
Date of Last Bone Density Test: _____

For Females:
Date of last Mammogram _____
Date of Last Breast and Pelvic Exam _____
Number of Prior Pregnancies _____
Number of Live Births: _____

For Males:
Date of Last Prostate Exam: _____

DOB and names of Children:

_____ _____

_____ _____

_____ _____

Have you had any surgeries? Please list type and approximate date:

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized? [ ] No [ ] Yes If yes, for what reason?

_____ _____

_____ _____

_____ _____

List prescription and over-the-counter medications you currently take:

_____ _____

_____ _____

_____ _____

_____ _____

Check the immunizations you've had. Please give the approximate date for each.

[ ] Influenza (Seasonal Flu) _____
[ ] Pneumonia _____
[ ] Chicken Pox _____
[ ] HPV Vaccine (Gardasil) _____
[ ] H1N1 Influenza _____
[ ] Shingles _____
[ ] Tetanus _____
[ ] Hepatitis B _____

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Cancer: type_____	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease or Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

SOCIAL HISTORY

Do you smoke? [ ] No [ ] Yes If yes, how much?_____

Did you ever smoke? [ ] No [ ] Yes If yes, for how many years? _____

Number of alcoholic drinks you consume per week?_____

Do you use street drugs? [ ] No [ ] Yes If yes, type_____

Gender Preference: [ ] Men [ ] Women [ ] Both

Are you: [ ] Single [ ] Married [ ] Partnered [ ] Separated [ ] Divorced [ ] Widowed

How often do you exercise and what activities do you do?_____

_____

_____

Do you work outside the home? [ ] No [ ] Yes: occupation _____

Do you have an end of life plan? (Living Will, Health Care Power of Attorney, Do Not Resuscitate, Do Not Intubate, Full Code). *We are happy to discuss the above as it is important for those of all ages.*

Patient Signature_____ Date:_____

(or parent if minor)

I was referred to Harnett Health by:_____

HARNETT HEALTH

PART ONE (To be completed by Patient)

SYMPTOMS	DESCRIPTIONS	YES	NO
1. COUGH	Currently have cough of greater than 3 weeks duration		
2. FEVER	Persistent fever elevations lasting greater than 3 weeks		
3. NIGHT SWEATS	Persistent sweating that leaves sheets and bedclothes wet		
4. COUGHING UP BLOOD	Any blood streaked sputum		
5. SOB/CHEST PAIN	Presently having shortness of breath or chest pain		
6. WT LOSS/ ANOREXIA	Loss of appetite with unexplained weight loss		

Patient signature:_____

If patient answered **Yes** to any questions above, offer tissues if patient is coughing and refer to medical personnel to complete PART TWO.

PART TWO (To be completed by Medical personnel use only to help determine infection status)

RISK FACTORS	YES	NO
1. Does patient have a past history of Tuberculosis or TB skin test conversion?		
2. Has patient been exposed to someone with known Tuberculosis infection?		
3. Is patient high risk due to: recurrent pneumonia, age, alcoholism, drug abuse?		
4. Does patient reside in a nursing home, shelter, prison, other public facility, or homeless?		
5. Was patient born, previously traveled to, or lived in a high-risk foreign country?		

FINDINGS: [ ] Low Risk for Tuberculosis [ ] High Risk for Tuberculosis

Comments/Actions:_____

_____

Completed by:_____

HARNETT HEALTH

Patient Name:_____ Date of Birth:_____

Request for Limitations and Restrictions of Protected Health Information

This form clarifies how we communicate your protected health information (PHI) with you in the event you cannot be reached directly. Your PHI includes general health information, laboratory tests, diagnostic test results, appointment reminders, and patient demographics/billing information.

Sensitive information such as HIV results, STD results, abnormal results and diagnosis will not be left as a message. **Information regarding sexually transmitted diseases will only be released to the patient.

1. You may leave me a message at the following telephone numbers:

   a. _____ Please Circle Cell Home Work

   b. _____ Please Circle Cell Home Work

   c. _____ Please Circle Cell Home Work

2. I authorize release of any and all of my PHI whether verbally or in writing to the following:

   Name:_____ Relationship:_____ Contact Number_____

   Name:_____ Relationship:_____ Contact Number_____

   Name:_____ Relationship:_____ Contact Number_____

3. Is it ok to mail PHI to your home? Yes_____ No_____

   Address for mailing:_____

I have reviewed and I understand this form.

Patient Signature:_____ Date:_____

Or Patient's Representative:_____
Date:_____

Practice Representative:_____ Date:_____

HARNETT HEALTH

Your Medical Chart Online via Allscripts Patient Portal

You can use our Allscripts Patient Portal to access your information securely and conveniently online. This is a service provided by Harnett Health.

You will have access to review your medical record...see labs and radiology reports at your convenience!!

We just need your email address. We will send you an invitation thru Follow My Health. Follow the directions within the email. It will ask for your security code/invitation code. The code is the last 4 digits of your social security number if you provided that information at registration. If we do not have that information, your code will be the year of your birth (1965,1970, etc...). You will be prompted to create a login and to change your password.

Please complete the information below and we will get you signed up

Name:_____

Email:_____

If you have any problems with the Patient Portal, please email

followmyhealth@harnetthealth.org

Our team will respond to you