Harnett Health

Location:
700 Tilghman Drive
Dunn, NC 28334
Phone: 910-892-4092
Fax: 910-892-0788

Office Hours:
Monday - Thursday 800am – 500pm
Friday 730am – 1130am

Welcome to Harnett OB/GYN

Thank you for choosing Harnett Obstetrics for your health and wellness needs. As an Obstetrics and Gynecology practice, we welcome patients from ages 16 and up. Patients under the age of 16 can be seen at the provider's discretion. Our approach to patient care is personal and caring. You will find that our office is relaxed and friendly, with qualified and caring professionals here to meet your needs. Our providers are:

Michael Zich, MD **Ogochukwu Okpala, MD**

We are here for you and hope to accommodate your appointments as needed. If you are sick, please contact our office immediately. We will make every effort to schedule an appointment for you the same day. However, keep in mind there may be a wait in the office if we have to work you in. Harnett Health System is a teaching facility; therefore, lending an opportunity to be seen by Campbell Residents who provide quality medical care and also aid in ease of making appointments either same or next day.

Harnett OB/GYN is currently accepting all insurance plans and will gladly file insurance on your behalf. We provide a discount for prompt payment to patients paying in cash as self-pay.

Please have with you at the first appointment:

- ✔ All medications
- ✔ Immunization Records
- ✔ Picture ID
- ✔ Insurance Cards
- ✔ Name/Address/telephone number of previous provider (if applicable)

Please finish all paperwork before your appointment time!

- Be sure to bring all medications to every appointment, as well as a list of any concerns you would like to talk about with your provider.

- **PRESCRIPTIONS AND REFILLS**
  Planning ahead is very beneficial in the area of prescription and refills. We encourage you to be aware of refill and expiration dates of your medications in order to avoid any lapse or delay. For refills, we ask that you obtain them at the time of service. Otherwise all other refill request must go through your pharmacy. Please allow 24 hours prior to requesting a prescription refill request.
  Unfortunately no prescription refills will be called in after hours or on the weekends.

- If you need any special accommodations for a disability, please inform us so we can better meet your needs. If there is any way we can improve your experience, please let us know. Your feedback is important to us.

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- We ask you to be on time for your appointments, if you are late for your appointment please call ahead. However understand that you may have to be rescheduled.

HARNETT HEALTH
Physician Office Practices

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____
State _____ Zip Code: _____
Home Phone Number: _____Cell Number: _____
Emergency Contact: _____ Phone Number: _____
Relation: _____
Email Address: _____
Race: ☐ White ☐Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other
Sex: ☐ Male ☐Female
Language: ☐ English ☐ Spanish ☐ Other: _____

RESPONSIBLE PARTY INFORMATION: (If not above)

Last Name: _____First Name: _____Middle: _____
Date of Birth: _____ Social Security Number: _____
Email: _____
Address: _____ City: _____
State _____ Zip Code: _____
Employer: _____ Occupation: _____
Work Phone Number: _____
Employer Address: _____ City: _____
State _____ Zip Code: _____
Home Phone Number: _____Cell Number: _____
Race: ☐ White ☐Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other
Sex: ☐ Male ☐Female
Language: ☐ English ☐ Spanish ☐ Other: _____
Marital Status: ☐Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Patients Relationship to Responsible Party: ☐ Self-18 ☐ Child

Is this visit related to:
☐ Industrial Were You Injured on The Job? ☐ Yes ☐ No Date of Injury: _____
Industrial Claim #: _____
☐ Accident Was an Automobile Involved? ☐ Yes ☐ No Date of Accident: _____
Attorney Name: _____
☐ Other ☐ Yes ☐ No Date of Accident: _____ Attorney Name: _____

PHARMACY:
Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____

Harnett Health

INSURANCE INFORMATION:

Primary Insurance Company: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____Subscribers date of birth: _____
Subscriber's Address: _____ City: _____
State: _____ Zip Code: _____
Subscriber's Social Security Number: _____
Subscriber's Sex: ☐ Male ☐ Female
Subscriber's Relationship to Responsible Party: ☐Self-1 ☐ Spouse-2 ☐ Other-0

Secondary Insurance Company: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____ Subscribers date of birth: _____
Subscriber's Address: _____ City: _____
State: _____ Zip Code: _____
Subscriber's Social Security Number: _____
Subscriber's Sex: ☐ Male ☐ Female
Subscriber's Relationship to Responsible Party: ☐Self-1 ☐ Spouse-2 ☐ Other-0

Tertiary (Third) Insurance Company: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____ Subscribers date of birth: _____
Subscriber's Address: _____ City: _____
State: _____ Zip Code: _____
Subscriber's Social Security Number: _____
Subscriber's Sex: ☐ Male ☐ Female
Subscriber's Relationship to Responsible Party: ☐Self-1 ☐ Spouse-2 ☐ Other-0

I, _____, certify that the completed information is correct and I received the Notice of Privacy Practice Form on ____/____/____.

Harnett Health

NO SHOW POLICY

A pattern of repeated "no shows" for appointments will result in dismissal from the practice. A "no show" is defined as a missed appointment in which the individual does not call to cancel or reschedule the appointment time.

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**

Harnett Health

Patient Name _____ **Date of Birth** _____

Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health Medical Services and its physicians and such assistants as a physician may designate 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 Medical Services physician in his or her medical judgment and such medical care, examination, or treatment as is reasonable incident thereto. I hereby authorize direct payment to Harnett Health Medical Services 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 Medical Services 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 Medical Services for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health Medical Services 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 Medical Services 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 Medical Services to me or the Patient stated above. I also hereby authorize Harnett Health Medical Services 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 Medical Services' 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 Medical Services 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 Medical Services.

Signature _____ Date _____

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

Harnett Health

HARNETT HEALTH
Physician Office Practices
Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis

Name: _____ Relationship: _____
Name: _____ Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". ☐ YES ☐ NO

5. Please print the telephone number where you want to receive calls about your appointments, lab and x- ray results, or other health care information if other than your home phone number: _____
"**I am fully aware that a cell phone is not a secure and private line."**

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? ☐ YES ☐ NO **(If no, you will not receive an appointment reminder.)**

7. Would you like to participate in the activation of FollowMyHealth? ☐ Yes ☐ No

Using FollowMyHealth, you can:

- Communicate with your care team
- Access your test results
- And more…..
- View your recent clinic visits
- Request Prescription Renewals

To join please provide your email where your activation code will be sent:

_____

8. I have been given a copy of my Patient Rights and Responsibilities. ☐ YES ☐ NO

9. I have been given a copy of the Joint Notice of Privacy Practices. ☐ YES ☐ NO

10. Advance Directives: Please check appropriate box.

Health Care Power of Attorney	☐ YES	☐ NO
	☐ YES	☐ NO
Living Will	☐ YES	☐ NO

Have you supplied us with a copy

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

Harnett Health

Print Name: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

Print Name: _____

Harnett Health

Medical History and Questionnaire

Primary Care Provider: _____

Medications (Include vitamins, herbs, and anything OTC):

Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

Allergies:

Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____

Menstrual Cycle:

Age of onset of menstrual cycle: _____ First day of last menstrual cycle: _____
If post-menopausal, date of your last cycle: _____

Procedures:

Date of last PAP smear: _____ Have you ever had an abnormal pap? Yes ☐ No ☐
Date of last mammogram: _____ Have you ever had an abnormal mammogram? Yes ☐ No ☐
Date of last colonoscopy: _____

Pregnancies:

(Please check one of these for Pregnancy Type)

Day/Month/Year of delivery or miscarriage	Vaginal	Cesarean	Abortion	Miscarriage	Ectopic	Preterm (Yes or no)	Live born (Yes or no)

Sexually Transmitted Diseases:

Have you ever had . . . ?

Chlamydia: Yes ☐ No ☐ Gonorrhea: Yes ☐ No ☐
Syphilis: Yes ☐ No ☐ HIV: Yes ☐ No ☐
Genital Warts: Yes ☐ No ☐ Genital Herpes: Yes ☐ No ☐

Harnett Health

Self & Family History

Please check the box if you or a family member have had any of these diseases.

	Self	Mother	Father	Sister	Brother	Grandparent
Asthma						
Diabetes						
Stroke						
Heart Disease						
Blood clots in arm or leg						
Problems with stopping bleeding						
High blood pressure						
High cholesterol						
Osteoporosis						
Hepatitis						
HIV/AIDS						
Tuberculosis						
Seizures						
Depression						
Anxiety						
Breast Cancer						
Colon Cancer						
Uterine Cancer						
Ovarian Cancer						
Thyroid problems						
Other: Please explain in space provided						