Advanced Primary Care
A Department of Columbus Regional Healthcare System

619 Jefferson Street • Whiteville, NC 28472
Phone: 910-642-0331 • **Fax:** 910-642-0597

ORG# _____

MRN# _____

Patient Registration - Adult

	Patient	Patient/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 Race _____	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

	Emergency Contact
Name	
Home Phone	
Work Phone	
Mobile Phone	
Relationship	

Reason for visit _____

_____

_____

Who Referred you? _____

Permission to leave voice mail @ primary phone number?

☐ 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 Columbus Regional Health 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: _____

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Adult Patient History

Date: _____
Chart # _____
MRN # _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse / Significant Other Name: _____ Education: Highest Level Completed _____

What is the reason for your visit today? _____ Who referred you? _____

Vaccines	Approximate Date	Exams	Approximate Date
Tetanus		Last Dental Exam	
Flu		Last Eye Exam	
Hep B		Last Chest X-ray	
Pneumovax		Last Colonoscopy / Sigmoidoscopy	
MMR		Last Pap Smear	
Chicken Pox		Last Physical Exam	
TB Skin Test Positive Negative		Last Prostate Exam / PSA	
		Others _____	

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y-yourself Al-mother F-father B-brother S-Sister GF-grandfather GM-grandmother C-child***

Condition	Relationship	Condition	Relationship
Heart disease		Rheumatic fever	
Lung disease *(asthma, bronchitis, emphysema, TB, etc)*		Stomach/Intestinal disorders	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*		Gallbladder disorders	
Stroke		Thyroid disorders (goiter)	
High Blood Pressure		Gout	
Diabetes		Skin disorders	
Liver disease *(hepatitis, cirrhosis, jaundice, etc)*		Depression or other Mental Illness	
Kidney disorders *(including kidney stones)*		Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Arthritis		Alcohol/Drug abuse	
Blood disorders *(anemia, bleeding disorders, etc.)*		Risk factors for HIV	
High Cholesterol		Migraines/Headaches	
Allergies *(food, seasonal)*		Other _____	

Current Medications -Prescription and Over-The-Counter Meds
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Name	mg	How many times per day
Birth Control *(Oral, Injectable)*		

Are you allergic to any medicine? ☐ Yes ☐ No
Please list all medications and reactions

Past hospitalizations/surgeries/serious injuries
(including blood transfusions)

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

Today's Date: _____

Chart # _____ MRN # _____

Name: _____

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INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite/ thirst change	☐	☐
4. Excessive fatigue/nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged /tender lymph nodes or glands	☐	☐
7. Other _____		

EYES	Yes	No
1. Do you wear glasses/ contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other _____		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing/ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other_____		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness/ drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores / ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth/gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea *(stop breathing while sleeping)*	☐	☐
10. Other _____		

PULMONARY	Yes	No
1. Shortness of breath/ difficulty breathing	☐	☐
2. Cough-dry /productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever/chills		
6. Other		

CARDIOVASCULAR	Yes	No
1. Heart attack/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/ Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL	Yes	No
1. Heartburn / indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/ diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black/bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems/jaundice/ hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other _____		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other	☐	☐

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam / PSA	☐	☐
8. Venereal disease	☐	☐
9. Genital concerns	☐	☐
10. Other _____		

FEMALES ONLY	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/ odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause / symptom	☐	☐
7. Trouble conceiving	☐	☐
8. Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year _____		
13. Do you use birth control Type _____	☐	☐
14. Date of last pap _____		
15. History of Abnormal Pap Treatment _____	☐	☐
16. Date of last mammogram _____		
17. Age at onset of periods _____		
18. Frequency of periods _____		

FEMALES ONLY *(continued)*

19. Last menstrual period _____
20. Pregnancies_____
21. Live births _____
22. Miscarriages/ abortions _____
23. Other _____

MUSCULOSKELETAL	Yes	No
1. Joint pain/tenderness	☐	☐
2 Joint swelling/ warmth	☐	☐
3. Joint stiffness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other _____		

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry /itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole/lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair/nail problems	☐	☐
9. Other _____		

NEUROLOGIC	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/ nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/ convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other _____		

PSYCHIATRIC	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐

URINARY	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other _____		

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

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PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

Thank you for choosing Advanced Primary Care for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare cost 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. Columbus Regional Health Network participate with **Traditional Medicare (Part A & Part B)** and a limited number of private fee-for-service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service Plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductible and co-insurance are expected at the time of service. As a participating provider with Medicare and a limited number of PFFS, 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.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. 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.

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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: _____

Relationship to Patient: _____ Self_____ Spouse _____ Other _____

Reason Patient Unable/Unwilling to Sign: _____

_____

Acknowledgement Form
Documento De Reconocimiento De Advanced Primary Care

Numero de Registro Medico _____

Nombre del Paciente: _____ Fecha de Nacimento ____/____/_____
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: _____

Relacion al Paciente: _____ Misco _____ Esposo (a) _____ Otro _____

Razon Por la Cual El Paciente No Puede/No Desea Fixmar: _____

_____

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Consent for Communication for Involvement of Care

I, the undersigned, do hereby consent and request that Advanced Primary Care communicate with or release health information concerning me, if communication is in my best interest and is only information that is directly relevant to designated individual's involvement with my healthcare and treatment decisions.

Patient's Name: _____ Date of Birth: _____

1. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to Patient: _____

Address: _____

_____

Phone # _____

2. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to Patient: _____

Address: _____

_____

Phone # _____

3. Name and address of person who I want to have health information as outlined above.

Name: _____ Relationship to Patient: _____

Address: _____

_____

Phone # _____

_____ _____

Signature of Patient or Authorized Party/Date Printed Name

I do not grant consent for anyone to be given information regarding my healthcare or treatment except required by law.

_____ _____

Signature of Patient or Authorized Party/Date Printed Name

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Medical Records Fax: 910-642-9302

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Patient Information: I give permission to release the health information of: **(One Patient Per From)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: ( ) _____

Email Address: _____

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s))	_____ (Name of facility, person, company) (Relationship)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

Purpose of Release (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment Dates: From _____ To _____
Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (Check all that may apply):
☐ Hospital Summary
☐ Discharge Summary
☐ History and Physical
☐ Consultation Reports
☐ Operative Reports
☐ Laboratory Reports
☐ Radiology/X-Ray Reports
☐ Pathology Reports
☐ Entire Record (Not including psychotherapy notes)
☐ Emergency Record
☐ Cardiac Reports/EKG
☐ Other _____

Office/Clinic (Check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other _____
☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD
☐ Email Address noted above, where permitted
☐ Paper Copy (charges may apply)
☐ Other _____

DELIVERY METHOD
☐ Reg. US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other _____ IF MORE THAN 25 PAGES, PLEASE MAIL

PATIENT'S RIGHTS - I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CRHS will not share or use my health information without my permission other than by ways listed in CRHS's Notice of Privacy Practices or as required by law. The Notice of Privacy is available at crhealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here : _____

Signature: _____ Print Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May Be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse** ☐ **Parent**
☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release: _____ **via** ☐ **Mail** ☐ **Fax** ☐ **Other** _____ ☐ **ID Verified** ☐ **DL/Other ID** _____

CRHS Employee Name & Title: _____ **CRHS Employee Signature:** _____ **DAte:** _____