Horizon Family Medicine, PA

PATIENT REGISTRATION FORM

PATIENT INFORMATION – *Please Print*

Legal Name (First, Middle, Last):_____Suffix: _____

SSN:_____Date of Birth:_____Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Address:_____City, ST, Zip: _____

Mailing Address:_____City, ST, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____(*This is part of your protected health record and will not be sold or spammed*)

Employer:_____Occupation: _____

Gender: ❑ Male ❑ Female Race: ❑ White/Caucasian ❑ Other ❑ Black/African American First Language: ❑ English ❑ Other ❑ Spanish Ethnicity: ❑ Hispanic ❑ Non-Hispanic

EMERGENCY CONTACT – *Who may we contact in case of an emergency?*

Name:_____Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY – *Custodial parent, if patient is under 18 years old*

Legal Name (First, MI, Last):_____ID #, DL # or SS #: _____

Relationship to Patient:_____Date of Birth:_____Employer: _____

INSURANCE –

	Primary Insurance	Secondary Insurance
Company		
Policy #		
Group #		
Policy Holder's Name		
Relationship to Patient		

PRIVACY INFORMATION (HIPAA)

I authorize Horizon Family Medicine to contact me and/or to leave telephone messages in the following ways:

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email

I authorize Horizon Family Medicine to release my medical information to the named persons listed below:

❑ Spouse/Parents/Children (Print Name):_____

❑ Other (Print Names and Relationship to the Patient):_____

READ & SIGN BELOW

I certify that the information provided is correct and complete to the best of my knowledge.

_____ _____

Signature of Patient (or Legal Guardian) **Date**

HFM-PR 042513

Horizon Family Medicine, PA
Multiple Locations With One Purpose...Your Health

Comprehensive Health Questionnaire

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Home/Alternative Phone: _____

Please describe the problem or concern that brought you to our office today:

☐ New Patient ☐ Other (briefly describe) _____

▶ **SPECIAL COMMUNICATION NEEDS**			
Your language preference:			
If "yes" to any of these questions below, how can we assist?			
Visual Impairment	☐ Yes ☐ No	Cognitive Impairment	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No	Sensory Impairment	☐ Yes ☐ No
Speech Impairment	☐ Yes ☐ No	Mental Impairment	☐ Yes ☐ No

▶ **SOCIAL HISTORY**
Please check appropriate answers below and provide explanations where appropriate
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Education level: ☐ Did not graduate ☐ High school ☐ Some college ☐ Bachelor's Degree ☐ Master's Degree or higher
Your occupation:
Occupational Concerns? ☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other? _____
How stressful would you rate your current living situation? No stress 1 2 3 4 5 6 7 8 9 10 Very stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, briefly describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

▶ **FAMILY HISTORY**			**Significant Medical Problems and/or Cause of Death** *(e.g. Diabetes, Heart Disease, High Blood Pressure, Cancer, Lung Disease, Liver Disease, Stroke, Kidney Disease, Depression or Bipolar Disorder, Osteoporosis, etc.)*
Relationship	**Living? Y/N**	**Age**	
Father			
Mother			
Siblings:			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
Children:			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
Have any of your relatives had the following conditions?			
☐ Mental Illness Relative:			
☐ Chemical Dependency Relative:			

CURRENT HEALTH CONCERNS: Please check problems or conditions you are ***CURRENTLY*** experiencing		
▶ **GENERAL:**	▶ **CARDIAC (heart):**	☐ Loss of interest in home and family
☐ Recent family illness or death	☐ Sleep with more than one pillow	☐ Previously had counseling or psychiatric care
☐ Any recent change in weight	☐ Chest pain	
☐ Recurrent fever or chills	☐ Swelling of ankles	
	☐ Fast or irregular heartbeat	▶ **GASTROINTESTINAL (Stomach):**
▶ **HEAD AND EYES:**	☐ Previous medication for heart	☐ Indigestion or heartburn
☐ Headaches more than once a week	☐ Past heart murmur	☐ Stomach pains
☐ Vision affected by headaches	☐ Past heart attack	☐ Vomiting blood
☐ Fainting spells	☐ High or low blood pressure	☐ Difficulty swallowing
☐ Injury to head		☐ Black or bloody bowel movements
☐ Dizziness	▶ **SKIN:**	☐ Frequent constipation
☐ Double or blurred vision	☐ Boils	☐ Rectal pain or bleeding
☐ Pain in eyes	☐ Black and blue spots without injury	☐ Intolerant of fried or fatty foods
☐ Decreased vision	☐ Cuts that are hard to heal	☐ Hepatitis
☐ Blind spots or blindness	☐ Colored moles that have recently changed	☐ Jaundice or yellowing of the skin
☐ Seeing colored halo around lights		☐ History of ulcer disease
	☐ Persistent rash	
▶ **EAR, NOSE & THROAT:**		▶ **URINARY:**
☐ Recent change in hearing	▶ **NEUROPSYCHIATRIC:**	☐ Urinate often at night
☐ Drainage from the ears	☐ Change in speech	☐ Pain or burning with urination
☐ Ringing or buzzing in the ears	☐ Losing track of thoughts	☐ Blood in the urine
☐ Head colds more than once a month	☐ Unable to express thoughts or feelings	☐ Loss of bladder control
☐ Nose bleeds for no apparent reason		☐ Urinate frequently during day (more than 5-6 times)
☐ Nasal drip without a cold	☐ Persistent numbness or tingling	
☐ Sinus problems	☐ Trouble coordinating	☐ History of kidney stones
☐ Hoarseness without a cold	☐ Loss of memory	
☐ Lumps or swelling in the neck	☐ Difficulty with words	▶ **MUSCULOSKELETAL:**
☐ Trouble swallowing	☐ Frequently ill	☐ Gout
☐ Change in voice	☐ Afraid to be alone	☐ Stiffness or pain in joints
☐ Thyroid enlargement (goiter)	☐ Finding decisions difficult	☐ Arthritis
	☐ Previously had a nervous breakdown	☐ Paralysis or weakness
▶ **RESPIRATORY (lungs):**	☐ Loss of appetite	☐ Back pain
☐ Frequent cough	☐ Unhappy with job	☐ Any type of body disability or deformity
☐ Coughing up sputum (mucus) Color_____ Amount per day _____	☐ Crying frequently	
	☐ Difficulty falling asleep	☐ More than 1" shorter than you were at age 25
☐ Coughing up blood	☐ Frequent spells of complete exhaustion	
☐ Chest colds more than twice a winter	☐ Often tired or exhausted in morning	
☐ Short of breath after walking _____ flights of stairs	☐ Severe aches/pains that make it impossible to work	▶ **ENDOCRINE (glands)**
		☐ Weight loss despite good appetite
☐ Asthma	☐ Feel unhappy and depressed	☐ Unusual loss of hair
☐ Night Sweats	☐ Life looks entirely hopeless	☐ Constantly thirsty
☐ TB exposure or past history of TB	☐ Wish that you were dead and away from it all	☐ Recent weight gain
☐ Hay Fever		☐ Craving sweets
	☐ Tremors or convulsions	☐ Hot or cold room intolerance
▶ OTHER (write in):	☐ Loss of interest in sex	
☐	☐ Currently living under tension	

▶ **WOMEN ONLY:**	▶ **MEN ONLY:**
☐ Number of pregnancies _____ Stillbirths _____ Miscarriages _____ Premature babies _____	☐ Trouble starting urinary stream
	☐ Reduced urinary stream
☐ Currently on birth control pills or hormones	☐ Cancer or tumor of the prostate
☐ Problems with pregnancy:_____ Describe: _____	☐ Lumps or sores on the penis, or discharge from the penis
☐ Babies over nine pounds at birth _____	☐ Loss of sexual ability or interest in sex
☐ Spotting between periods or after sex	☐ Rupture
☐ Not having periods now Date of last period: _____	☐ Enlarged, swollen, tender or hard testicles
	☐ A doctor informed you that your prostate is enlarged
☐ Excessive vaginal discharge	
☐ Lump or pain in breasts	
☐ Severe pain with periods	

▶ **COMMENTS ABOUT ITEMS YOU CHECKED:**

▶ **LIST OTHER THINGS YOU WOULD LIKE YOUR DOCTOR TO KNOW:**

▶ **PERSONAL HEALTH HISTORY**		▶ **PREVIOUS SURGICAL PROCEDURES**	
Please check past or current problems/conditions		Please check and list date if you have had any of the following:	
☐ Hypertension	☐ Seizures	☐ Heart surgery	Date:
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	Date:
☐ Diabetes	☐ Stroke	☐ Vascular surgery/stent	Date:
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	Date:
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	Date:
☐Congestive heart failure	☐ Urinary tract infection	☐ Gallbladder removed	Date:
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	Date:
☐ Emphysema or chronic bronchitis	☐ Cancer (please list type)	☐ Tonsillectomy	Date:
☐ Pneumonia		☐ Joint replacement	Date:
☐ Gastroesophageal reflux disease	☐ Thyroid problem	☐ Breast cancer surgery	Date:
☐ Stomach ulcer	☐ Bleeding disorder	☐ Hernia	Date:
☐ Kidney problems	☐ Addiction issues	☐ Pacemaker	Date:
☐ Liver disease/hepatitis	☐ Depression anxiety	☐ Other: (describe and list date)	
☐ Colon cancer	☐ Mental illness		
☐ Bowel/digestive problem	☐ Other: (describe)		

▶ **ALLERGIES:** *Please list any allergies to medications or foods*	

▶ **ANY OTHER INFORMATION YOU WOULD LIKE YOUR DOCTOR TO KNOW:**

▶ **MEDICATIONS:** *Please list any medications you take, including over-the-counter, herbs and supplements. Include the dose and frequency.*

▶ **HEALTH MAINTENANCE:** *Please check if you have had the following preventive services. Please list year of service.*

Immunizations			**Year**	**Tests**			**Year**
Tetanus vaccine/Tdap	☐ Yes	☐ No		Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		Bone density scan	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
				Prostate test	☐ Yes	☐ No	

▶ **HEALTH BEHAVIORS**

Tobacco use: ☐ Never ☐ Quit (when) _____ ☐ Current smoker ☐ Currently chew tobacco ☐ Snuff

If current smoker, how many packs per day? _____ for how many years? _____

If currently using chewing tobacco, for how long? _____

Alcohol intake: ☐ None ☐ Yes If yes, how many drinks?_____ and how often? _____

Illicit drug use (including marijuana, cocaine, steroids, etc.) ☐ Never ☐ Past ☐ Current

If current illicit drug user, please describe:

Exposure to second hand smoke	☐ Yes	☐ No	Wear a seatbelt	☐ Yes	☐ No
Eat a diet high in fruits and vegetables	☐ Yes	☐ No	See dentist at least once per year	☐ Yes	☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes	☐ No	Wear sunscreen	☐ Yes	☐ No

▶ **SPECIALTY PROVIDERS:** *So that we can best coordinate your care, please list any medical providers you see outside of this practice and the year you last saw them.*

☐ Eye doctor	Year last seen:	☐ Neurologist	Year last seen:
☐ Cardiologist	Year last seen:	☐ Psychiatrist	Year last seen:
☐ Oncologist	Year last seen:	☐ Allergist	Year last seen:
☐ Urologist/Gynecologist	Year last seen:	☐ Vascular	Year last seen:
☐ Gastroenterologist	Year last seen:	☐ Pulmonologist	Year last seen:
☐ Endocrinologist	Year last seen:	☐ Other	Year last seen:

▶ **ADVANCE CARE PLANNING:** *Do you currently have, or would you like information on any of the following items:*

☐ Living Will	☐ Have	☐ Don't have	☐ Would like information
☐ Durable Power of Attorney	☐ Have	☐ Don't have	☐ Would like information
☐ DNR ("Do Not Resuscitate")	☐ Have	☐ Don't have	☐ Would like information

☐ Other:

▶ **FALL RISK SCREENING**	
☐ Have you fallen within the last 12 months?	☐ Yes ☐ No ☐ Unsure
☐ If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
☐ Were you injured as a result of this fall?	☐ No ☐ Yes If yes, please briefly describe injury:

▶ **MOOD SCREENING:** *A person's mood can have a strong influence on their health status and overall wellbeing. Over the past two weeks, how often have you been bothered by any of the following problems?*

Little interest or pleasure in doing things:	**Feeling down, depressed or hopeless:**
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

▶ **HEALTH LITERACY QUESTIONNAIRE:** *Sometimes healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10, with 1 being Strongly Disagree and 10 being Strongly Agree*

	Strongly Disagree									Strongly Agree
I feel that I have a thorough understanding of the instructions my doctors and nurses give me about health	1	2	3	4	5	6	7	8	9	10
I feel that, after I return home, I remember the instructions given to me at my doctor's office	1	2	3	4	5	6	7	8	9	10
I feel that I have a good understanding of medical language	1	2	3	4	5	6	7	8	9	10

▶ **HOW ARE YOU DOING?**
Do you spend time with family and/or friends? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you participate in social activities? ☐ Frequently ☐ Occasionally ☐ Rarely
Have you recently felt isolated from other people? ☐ Frequently ☐ Occasionally ☐ Rarely
Have you recently had difficulty performing daily tasks? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you have regular access to nutritional food? ☐ Frequently ☐ Occasionally ☐ Rarely
Do you have transportation for medical appointments and other activities? ☐ Always ☐ Most of the time ☐ Rarely
Do you miss doctor appointments because you have no means of travel? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never
* If you use the internet, please visit our website at horizonfamilymed.com for information about resources available to you. And, look for the Community Resources flyer posted in your clinic's lobby- it also lists the resources!

Patient Signature: _____ Date: _____

Legal Representative Signature (if applicable) _____ Date: _____

Clear Form

Print Form

MR #

Horizon Family Medicine, PA

Five Locations With One Purpose . . . Your Health

www.horizonfamilymed.com

410 Canterbury Road	236 Butternut Lane	864 Black Creek Road	213 Barden Street	100 Cunningham Lane, Ste 103
Smithfield, NC 27577	Clayton, NC 27520	Four Oaks, NC 27524	Princeton, NC 27569	Clayton, NC 27527
Phone: (919) 934-5149	Phone: (919) 359-1011	Phone: (919) 963-3148	Phone: (919) 936-5171	Phone: (919) 359-6016
Fax: (919) 934-5632	Fax: (919) 359-9122	Fax: (919) 963-2900	Fax: (919) 936-2328	Fax: (919) 936-2328

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Other Name: _____

Street:_____ City, ST Zip: _____

Date of Birth: _____/_____/_____ Phone: _____ Cell: _____

I authorize the release of medical information as indicated below:

FROM

Practice: _____

Attn: _____

Street: _____

City, ST Zip: _____

Phone: _____

Fax: _____

TO

Practice: _____

Attn: _____

Street: _____

City, ST Zip: _____

Phone: _____

Fax: _____

IF MORE THAN 10 PAGES, PLEASE MAIL RECORDS. DO NOT FAX.

- ❑ I would like to pick up my records, please call me at the number above.
- ❑ I would like the records mailed (please indicate the address above).

What to Release: Please choose the records you would like released:

- ❑ Outpatient note(s)
- ❑ X-Ray report(s)/film(s)
- ❑ Laboratory reports(s)
- ❑ Immunization record
- ❑ Pathology reports(s)
- ❑ ALL Medical records
- ❑ Other, please specify:_____

NOTE: The records listed below have special protection by law. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including results of HIV tests	❑ Yes	❑ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	❑ Yes	❑ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	❑ Yes	❑ No/NA

Purpose of the release: Please indicate the reason for this release:

- ❑ Transfer care
- ❑ For use in a lawsuit
- ❑ Follow-up related to an injury
- ❑ Personal use
- ❑ To obtain disability
- ❑ Worker's compensation
- ❑ Armed Forces requirement
- ❑ For another doctor
- ❑ Other, please specify:_____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

❑ Please change the expiration date to last for _____days.

I understand this Authorization can be revoked at any time according to Horizon Family Medicine's privacy practices. This request must be made in writing. Once these records are released, the information is not protected by Horizon Family Medicine and may potentially be re-disclosed by the party who received these records. Horizon Family Medicine, its employees and officers, and attending physicians are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form, and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____

Signature of Patient Date

_____ _____

Signature of Legal Representative AND Relationship to Patient Date

_____ _____

Signature of Witness Date

Horizon Family Medicine, PA

www.horizonfamilymed.com

PROMISSORY NOTE

PLEASE CHOOSE YOUR PAYMENT SOURCE

Legal Name (First, Middle, Last): _____ Date of Birth: _____

PRIVATE PAY

I, _____am acknowledging that I am a self paying patient seeking medical attention. I agree to pay my balance in full at the time of service or to pay 50% of my balance now and the remainder in full within 30 days or I will agree to a payment arrangement with the Billing Office before leaving the building and satisfying my agreement before my next scheduled visit.

INSURANCE

I, _____acknowledge that my claim will be sent to my insurance carrier for reimbursement. I will be responsible for the remaining balance (if any) in accordance with my insurance plan. Such payments will be paid within 30 days of receipt of statement or I will contact the Billing Office to make payment arrangements.

WORKMANS COMPENSATION

I, _____acknowledge that a claim will be filed with my workman compensation carrier. If my claim is denied, I will be responsible for all charges on the account. Such payments will be paid within 30 days of receipt of statement. It is my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

PERSONAL INJURY

I, _____acknowledge that a claim will be filed with my attorney, private insurance and/or claim adjustor. I will be responsible for all claims if payment is not received within 30 days. Such payments will be paid upon receipt of statement. It is my responsibility to supply Horizon Family Medicine with the information needed to process any and all claims.

_____ _____

Signature of Patient (or Legal Guardian) **Date**

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FINANCIAL & OFFICE POLICY

FINANCIAL POLICY

Legal Name (First, Middle, Last): _____ Date of Birth: _____

Thank you for choosing Horizon Family Medicine, PA for your family's medical care. We are committed to providing you with quality health care. We appreciate your commitment to adhere to this agreement.

- **INSURANCE** – Your medical insurance is a contract between you and your insurance company. Horizon Family Medicine is not a party to that contract. We will file insurance claims on your behalf, as a courtesy. In order for your claims to be processed timely and accurately **you must present a current insurance card and state issued photo ID at each visit**. 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. Horizon Family Medicine policy is to have **Social Security numbers on all patients** to file insurance claims – this helps protect the patient and Horizon Family Medicine from insurance fraud. All information provided to us is part of your confidential health record and is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
  - **Claim Submission** – If your insurance company requires you to supply information to them for processing of a claim you must comply with their request in a timely manner. **If your insurance company has not processed a claim on your behalf within 90 days of submission due to information that you have not provided, the balance will be transferred to your responsibility.** If a payment is received for that claim, you will be reimbursed by Horizon Family Medicine, PA within 15 business days.
  - **Medicare** – Medicare deductibles & co-insurances are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier. Please notify the front desk staff if you have recently changed Medicare plans. Third-party claims are the responsibility of the patient.
  - **Non-Contracted Insurance Plans** – Payment is required at time of service.
- **CO-PAYMENTS/DEDUCTIBLES/PAYMENTS** – **Payment is required at the time of service.** We currently accept Cash, Personal Checks, Visa, MasterCard, and Discover. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office **PRIOR** to your appointment to discuss payment arrangements. **There will be a $35.00 service charge for all returned checks.**
  - **Self-Pay** – Uninsured patients are classified as Self-Pay. We can provide an estimate of our fees prior to services in the office. This is only an estimate actual charges may be higher or lower. Self-Pay patients may be given a **30% "Prompt Pay" savings** when their balance is paid at the time of service. You may also contact the Billing Office for payment arrangements.
- **MINORS** – **Parents and guardians are responsible for payments for their dependants at the time of service.** Patients between the ages of 16 and 18 can be seen without a parent or guardian present as long as parent or guardian is reachable by phone.
- **MISSED APPOINTMENTS** – Unless cancelled at least 24 hours in advance, a charge of **$30 for missed appointments** may be applied. This fee is NOT covered by your insurance plan and is your responsibility.

OFFICE POLICY

- **LATE** – If you arrive more than 15 minutes late for your appointment you will be asked to reschedule.
- **PRESCRIPTION REFILLS** – Call your pharmacy and ask them to **fax a refill request to our office**. DO NOT wait until you are out of your medicine. Refill requests take 24-48 business hours.
- **FORMS** – Forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork –will be completed within 7-10 business days with a fee of $15 due upon receipt. Please make sure to allow plenty of time for completion. Emergencies will be handled on a case by case basis.
- **PATIENT CONFIDENTIALITY** – In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Horizon Family Medicine Notice of Privacy Practices is available to all patients in the office or online at www.HorizonFamilyMed.com.

READ & SIGN BELOW

I have read, understand and agree to the above Financial & Office Policy. I authorize Horizon Family Medicine to furnish medical information regarding my examinations and treatments to my insurance carriers, and assign all benefits payable to Horizon Family Medicine to be used towards the payment of my account.

_____ _____

Signature of Patient (or Legal Guardian) **Date**