Regional Physicians
HIGH POINT REGIONAL HEALTH SYSTEM

Adams Farm Shopping Center
5710-I High Point Road
Greensboro, NC 27407
Phone: (336) 299-7000; Fax: (336) 299-7003

Welcome to Regional Physicians Family Medicine-Adams Farm. We are pleased that you have chosen us to be your primary care provider. Enclosed you will find our *New Patient Packet*.

In order for us to schedule an appointment we need you to thoroughly complete the enclosed packet and return to us via mail, fax or you may drop it off at our office. We are open M-F from 8am-5pm and are closed between 12-1pm for lunch. It is VERY IMPORTANT that the Medical History Forms be completed in full. In the event that these two forms are not completed in full, we will return them to you for proper completion prior to scheduling your appointment.

If you are transferring your healthcare from another provider or facility to our office, you may contact that physician or facility to have them transfer your records to us. However, for your convenience there is a "release of medical records" enclosed. If you would like for us to request your records, please complete this form in its entirety. **Please note: For children ages 18 & under—we MUST have immunization record (s) prior to their scheduled appointment.**

As a new patient, please arrive 30 minutes prior to your scheduled appointment time. Bring your insurance card, photo ID, necessary eyeglasses, and ALL medications in their original containers. Copays and deductibles are due at the time of service. If you do not have insurance you will be responsible for payment in full at the time of your visit.

Thank you again for choosing Regional Physicians Family Medicine-Adams Farm. We look forward to serving your healthcare needs.

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Patient Information Sheet

Patient's Full Legal Name: _____
(First) (Middle) (Last)

Social Security Number: _____ Sex: ___Male ___Female Date of Birth: _____ Age: _____

Marital Status: (Circle One) Single Married Widowed Divorced Separated

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please check ONE in EACH CATEGORY that applies)

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Refused to Report/Unreported ☐ More than one ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Undefined	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report/ Unreported ☐ Undefined	☐ English ☐ Spanish ☐ Urdu ☐ Refused to report/Unreported ☐ Other: _____ ☐ Hindi ☐ Vietnamese

PATIENT ADDRESS INFORMATION

Address: _____
Street City State Zip Code

EMAIL Address: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ ext. _____

Cell Phone: (_____)_____

Primary Care Physician: _____ Referring Provider Name: _____

HOW DID YOU HEAR ABOUT US? (Please check the ONE that applies)

□ Family/Friend	□ Online Yellow Pages	□ Employer Website	□ Internet Search	□ Billboard
□ Hospital	□ Newspaper	□ Mailer	□ Radio	□ Doctor
□ Seminar/Special Event	□ Sports Team Support	□ TV	□ Worker's Comp	□ Other: _____
□ Existing Patient	□ Self Referral	□ Phone Book		□ Other: _____

IS THIS A WORKERS COMPENSATION CLAIM? (CIRCLE ONE) YES NO

If yes, patient should also fill out Work Comp Info Sheet

DID YOUR EMPLOYER SEND YOU HERE FOR A SCREENING, PHYSICAL, OR VACCINATION?

(CIRCLE ONE) YES NO

If yes, patient should also fill out OHC info sheet.

PLEASE HAVE YOUR INSURANCE CARD (S) AND PHOTO ID READY TO BE COPIED

GROUP INSURANCE INFORMATION

Primary Insurance:_____ **Member ID:** _____

Policyholder Name:_____ **Policyholder Date of Birth:**_____

Group #:_____ **Patient's relation to policyholder: (Circle One)** Self Wife Husband Child Parent Other

Secondary Insurance:_____ **Member ID:** _____

Policyholder Name:_____ **Policyholder Date of Birth:**_____

Group #:_____ **Patient's relation to policyholder: (Circle One)** Self Wife Husband Child Parent Other

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW

Parent/Guardian/Guarantor Name: _____

Address: _____
(If different from above) Street City State Zip Code

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Social Security #: _____ Date of Birth: _____ Sex: _____M _____F

Marital Status: (Circle One) Single Married Widowed Divorced Separated

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment**: I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information**: I authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits**: I authorize payment of medical benefits to Regional Physicians, LLC.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Regional Physicians for charges not covered by insurance.

_____ _____
Signature of Patient or Legal Representative Date

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Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Regional Physicians Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Signature of Patient or Guardian Date

1. Please list the family members and/or other persons, if any, whom we my inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

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

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

   Name: _____ Phone #: _____

3. Please list the telephone number(s) where you want to receive calls about your appointments, lab and x-ray results, or other health information:

   _____ _____

4. Can confidential messages (i.e. appointment information) be left on your answering machine? ____ Yes ____ No

5. Can we send you the following information electronically?

   - Information about your medical conditions? ____ Yes ____ No
   - Information about health-related benefits or services that may be of interest to you? ____ Yes ____ No
   - Information about potential treatment options or alternatives? ____ Yes ____ No
   - Appointment reminders? ____ Yes ____ No

****Please note that if individuals other than you have access to the contents of this electronic mail address, those individuals could also have access to any information we send to you at that address. Regional Physicians will not be responsible if such individuals access information that is sent to the electronic mail address you provide.****

Please note that while we may ask you from time to time if there have been any changes to this information, It is your responsibility to update this information as needed.

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below:

Presented on (date): _____ Name/Title:_____

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CONSENT FOR RELEASE OF MEDICAL RECORDS

You may encounter fees for release of medical records

FOR: Patient's Name: _____

Patient's Address: _____

Patient's Birth Date: _____

Patient's Social Security Number (*last 4 digits only*): XXX-XX-_____

RECORDS REQUESTED FROM:

Practice/Physician Name: _____

Physician Address: _____

Physician Phone #: _____ Fax #: _____

I do hereby consent and authorize you to release copies of my medical records. PLEASE NOTE: This authorization includes consent for release of alcohol, drug, psychiatric information, and any information relating to HIV testing, AIDS, and AIDS-Related Syndrome, which may be included in my records. It also may include information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as the original. Please send copies of all requested information as soon as possible to the address listed below.

_____ Send all of my records

_____ Sensitive information has been deleted at the patient's request

_____ Send records from (date): _____

SEND RECORDS TO:

_____

_____

_____

PURPOSE/USE OF THE REQUESTED INFORMATION:

_____ 2nd Opinion

_____ Sharing with other Health Care Provider

_____ Transfer of Care (This means you will no longer see the provider that the records are requested from)

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

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For office use only:
Appointment Date: _____
Appointment Time: _____
Provider: _____
Scheduler's initials: _____

Pediatric (0-17 years of age) Medical History Form

Please complete all information on this form to the best of your knowledge.
If none in a particular section, write n/a or none.

Patient Name: _____ **Date of Birth:** _____

Name of person completing form: _____ Date: _____

Past Medical History: (Please check all items that you have had in the past)

□ Acne	□ Autism	□ Depression	□ Hepatitis	□ Rash	□ Vision Prob.
□ Anemia	□ Cancer	□ Diabetes	□ Jaundice	□ Seizures	□ Reading Prob
□ Asthma	□ Chickenpox	□ Emotional prob.	□ Joint problems	□ Skin problems	□ _____
□ ADD	□ Colic	□ Headache	□ Murmurs	□ Tumors	□ _____
□ ADHD	□ Constipation	□ Hearing loss	□ Chronic ear infections	□ Weakness	□ _____

Allergies: (List allergen name and the type of reaction)

Medication (s):_____ Reaction: _____

Medication (s):_____ Reaction: _____

Food/Insects/Other: _____ Reaction: _____

Immunizations: (Attach current immunization record)

Family History: (List any major medical conditions, mental health conditions, and substance abuse conditions that your Mother, Father, Maternal Grandparents, Paternal Grandparents, Aunts, Uncles and Siblings may have. Example Mother/Diabetes)

_____/_____ _____/_____ _____/_____
_____/_____ _____/_____ _____/_____
_____/_____ _____/_____ _____/_____

Social History:

Family:
Primary language spoken: _____ Who lives in the home with the patient?_____
Mother's education level: _____ Father's education level: _____

Environment/Home:
Home location: City Rural
Type of home: Apartment House Other: _____
Water: Public Well Heat/Air: Electric Gas Central (Heat Pump) Other: _____
Guns in home? ____ Yes ____ No Pets? ____ Yes ____ No; If yes, type: _____
Tobacco/smoke exposure? ____ Yes ____ No; If yes, who? _____ How much? _____

Exercise: ____ Yes ____ No; If yes: _____x/week Type: _____

Substance Abuse:
Alcohol use? ____ Yes ____ No How much? _____ Drug use? ____ Yes ____ No
Tobacco Use? ____ Yes ____ No How much? _____ How long? _____

School Activities:
School Name: _____ Attendance: Good Fair Poor Performance/Grades: _____
Other activities outside of school? _____

Safety:
Seat belt use? ____ Yes ____ No Helmet use? ____ Yes ____ No

Do you have any cultural or religious beliefs that we need to be aware of in providing your care?:
____ Yes ____ No; If yes describe: _____

Present Medications: **(List the name and dose of each medication you are currently taking.)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries: **(Check all surgeries that the patient has had.)**

□ Adenoidectomy (adenoids)
□ Appendectomy (appendix)
□ Cholecystectomy (Gall bladder)
□ Congenital heart disease surgery
□ Fracture repair: _____
□ Inguinal hernia repair
□ Myringotomy (ear tubes)
□ Pyloric stenosis repair
□ Tonsillectomy (tonsils)
□ Umbilical hernia repair
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____
□ _____

Symptoms: (Check all symptoms that you currently have)

General:
__ Chills
__ Fair Health
__ Fatigue
__ Fever
__ Good Health
__ Night sweats
__ Poor Health
__ Sleep difficulties
__ Weight Gain
__ Weight Loss

Skin:
__ Bruising
__ Changes in Moles
__ Dryness
__ Hair Loss
__ Itching/Rash
__ New lesions
__ Scalp problems
__ Yellowing of skin

Eye/Ear/Nose/Throat:
__ Earache
__ Gums bleeding
__ Hearing decreased
__ Nose bleeds
__ Ringing in ears
__ Runny Nose
__ Sinus Pain
__ Sore Throat
__ Throat hoarseness
__ Visual disturbances

Neck:
__ Neck Mass
__ Neck Pain
__ Swollen Glands

Respiratory:
__ Cough
__ Coughing up blood
__ Shortness of breath
__ Sputum production
__ Wheezing

Breast:
__ Breast pain
__ Breast lump
__ Nipple discharge

Cardiovascular:
__ Chest pain
__ Chest pressure
__ Palpitations

Gastrointestinal:
__ Abdominal pain
__ Black, tarry stool
__ Constipation
__ Diarrhea
__ Difficulty swallowing
__ Nausea
__ Rectal bleeding
__ Vomiting
__ Vomiting blood

Female Genitourinary:
__ Pelvic pain
__ Urinary Complaints
__ Vaginal bleeding problem
__ Vaginal discharge

Male Genitourinary:
__ Blood in urine
__ Penile discharge
__ Urination difficulty

Musculoskeletal:
__ Joint pain
__ Muscle pain
__ Muscle weakness
__ Swelling of area: _____

Neurological:
__ Dizziness
__ Fainting spells
__ Headaches
__ Memory problems
__ Numbness
__ Seizures
__ Tremors
__ Weakness

Psychiatric:
__ Anxiety
__ Depression
__ Mood swings

Endocrine:
__ Appetite changes
__ Excessive thirst

Hematology:
__ Anemia
__ Gums bleeding

Do you have any specific questions that you want your doctor to address? _____

_____

_____

_____

Preferred Pharmacy: _____ **Address**: _____