New Patient Information Sheet

How did you hear about us? Friend □ Radio Ad □ Newspaper Ad □ Flyer □ Community Event □

Section 1: Patient Information

If the patient is under the age of 18, please complete **Section 3 of this form- **Responsible Party/Parent Information****

Patient Name: _____, _____ _____
Last Name First Name M.I.

Mailing Address: _____ **Physical Address** (if different): _____
PO Box or Street Street

City: _____ **State**: _____ **Zip Code**: _____ **County**: _____

Social Security Number: _____-_____-_____ **Birth Date**: ____ /____ /____ **Birth City and State: _____**
Month Day Year

Phone Number: (____) _____ **Cell Number**: (____) _____ **Driver's License #**: _____ **State**: ____

Email Address: _____

Employer: _____ **Employer Address**: _____
Employer Phone Number: (____) _____
Occupation: _____

What is your Gender Identity: Male_____ Female_____ Transgender_____ I choose not to disclose_____

What is your Sexual Orientation: Heterosexual_____ Homosexual_____ I choose not to disclose_____

Marital Status: Married Single Widowed Other: _____

Employment: Disabled Full-time Part-time Retired Self-employed Unemployed

Student: Fulltime Part-time N/A

Military: Active Retired Veteran None

Language: English Spanish Other (please specify) _____

Race: Black/African-American American Indian Asian Caucasian Hispanic Pacific Islander More than one race

Ethnicity: American Indian Asian African American Hispanic Native Hawaiian Pacific Islander Caucasian

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Emergency Contact: _____ _____ _____
First name **Last Name** **Phone Number**

Do you work in the fields or with produce: YES NO **Farmworker**: Migrant Seasonal Not Applicable

Do you live in a: Doubling up (two or more families) Shelter Transitional Housing Street/Vehicle Not Homeless
Public Housing: Family Tenant Section 8 Senior Housing Vicinity of Section 8 Not Applicable

Number of Children in household/family: _____ **Number of adults in household/family**: _____

Smoker: Yes_____ NO_____

Section 2: Insurance Information **(Please present a current copy of your insurance card(s) to the Front Desk)**

Are you the responsible party for Bill: yes ☐ no ☐ (If you are not the responsible party please complete Section 3)

Do you (the patient) have: Medical Insurance: yes ☐ no ☐ Dental Insurance: yes ☐ no ☐

If you answered yes to the above question, what type of insurance do you have (check all that apply**):**

Medicaid ☐ NC Health Choice ☐ Medicare ☐ Commercial/Private Insurance ☐ Dental Insurance ☐

Insurance Carrier Name: _____

Insurance Policy Number: _____ / Group Number: _____

Are you the primary insurance policy holder: yes ☐ no ☐

If you are not the policy holder, who is the primary insurance policy holder: _____

Your relationship to the Insurance Policy

holder: Spouse ☐ Child ☐ Other ☐ _____

Section 3: Responsible Party/Parent Information

Name: _____ Social Security #: _____-_____-_____

Is your address the same as the patients: yes ☐ no ☐

If no, what is your full mailing address: _____

Phone Number: _____ Driver's License # _____ State: _____

Date of Birth: _____ /_____ /_____ Gender: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Other ☐

Occupation: _____

Employment: Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Un-employed ☐ Disabled ☐ Seasonal Worker ☐

AUTHORIZATION FOR TREATMENT

I, the undersigned hereby authorize PFMC and (PCP Name) _____ (and whomever he/she may designate and His/Her assistants) to administer such treatments as necessary. I also certify that no guarantee off assurance has been made to results of this treatment.

Signed: _____ Date: _____

Name (if signed by someone other than the patient): _____ Relationship: _____

Witness (Office Personnel): _____ Date: _____ Time: _____

You will be expected to pay any insurance co-pays at the time of visit and/or payment for services **NOT** covered by your insurance. If you feel you are unable to pay the full charge for your medical treatment, please inquire about our **SLIDING FEE APPLICATION.** If you do not qualify for sliding fee and are unable to pay at the time of treatment, please speak with billing before receiving treatment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND BENEFIT ASSIGNMENT

PFMC is authorized to release any medical information required in processing of applications for financial coverage for services rendered and authorized to request payment for benefits directly to PFMC ON MY BEHALF.

Signed: _____ Date: _____

*This organization is required to maintain privacy and confidentiality for your health information and provide you with notice as to our legal duties and Privacy Practices with respect to information we collect and maintain about you.**

You must provide income verification in the form of check stub, W-2, or income statement from an employer. If you DO NOT wish to provide this information, you are declining the "sliding fee scale" and will be charged at 100% for your treatment.

_____ Yes, I will provide income verification within 7 days and annually, and if I fail to return the required documentation within the 7 days and annually, I agree to be charged at 100%.

_____ No, I have been offered the "sliding fee scale", but I decline to participate and I will pay at 100% for my treatment.

PERSON FAMILY MEDICAL AND DENTAL CENTER

The following information is requested by the Federal Government in order to monitor compliance with Federal Laws prohibiting discrimination against users of Person Family Medical and Dental Center. You are not required to furnish this information, but you are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

Income Category: Please place a check mark in appropriate box [] to indicate your annual household income.

	Number in Family	Annual Family Income
□	1	$ 0 - $10,890
□	1	$ 10,891 - $13,613
□	1	$ 13,614 - $16,335
□	1	More than $19,058
□	2	$0 - $14,710
□	2	$14,711 - $18,388
□	2	$18,389 - $22,065
□	2	More than $22,066
□	3	$0 - $18,530
□	3	$18,531 - $23,163
□	3	$23,164 - $27,795
□	3	More than $27,796
□	4	$0 - $22,350
□	4	$22,351 - $27,938
□	4	$27,939 - $33,525
□	4	More than $33,526
□	5	$0 - $26,170
□	5	$26,171 - $32,713
□	5	$32,714 - $39,255
□	5	More than $39,256
□	6	$0 - $29,990
□	6	$29,991 - $37,488
□	6	$37,489 - $44,985
□	6	More than $44,986
□	7	$0 - $33,810
□	7	$33,811 - $42,263
□	7	$42,264 - $50,715
□	7	More than $50,716
□	8	$0 - $37,630
□	8	$37,631 - $47,038
□	8	$47,039 - $56,445
□	8	More than $56,446

PERSON FAMILY MEDICAL AND DENTAL CENTER

P.O. Box 350
702 N. Main St.
Roxboro, NC 27573
Telephone: (336) 599-9271 Fax: (336) 599-0969

INFORMED CONSENT FORM FOR THE TESTING FOR ANTIBODIES TO HEPATITIS B AND HIV III

I, hereby, authorize Person Family Medical and Dental Center laboratory to perform a venipuncture and to obtain the necessary amount of blood needed to properly test my blood for antibodies to the Hepatitis B (HBV) and HIV (AIDS) virus, in the event a Person Family Medical and Dental Center's employee is punctured with an instrument and/or needle that has been contaminated with the undersigned patient's bodily fluids.

Results of this test will be forwarded to your physician. He/She will counsel you on what the results read and what the test means. A copy will be kept here in our office as well. Test results take approximately four to five
(4 to 5) business days to return. It will be your responsibility to return within in six (6) months for another blood test to finish all the testing needed.

_____ _____
(Name of Patient's Primary Care Provider) (Office Phone Number)

_____ _____
(Patient/Parent/Guardian) Printed Name (Date)

_____
(Patient/Parent/Guardian) Signature

_____ _____
Technician Printed Name Date

_____
Technician Signature

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patients Name: _____ **Date of Birth:** _____
(please print)

I have been presented with a copy of Person Family Medical and Dental Center's 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 this Notice.

I understand I have the right to request restrictions concerning the use of my information. I request the following restrictions:

_____
_____
_____
_____

With whom may we discuss your treatment?

_____
_____
_____
_____

With whom may we discuss your payment?

_____
_____
_____
_____

Patient Signature: _____ Date: _____
If not signed by the patient, please indicate your relationship to the patient

Relationship to patient: _____ Witnessed By: _____

(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 the patient and sign below.

Presented on (Date): _____ Time: _____
By: _____ Title: _____
(Name of Office Personnel)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECETED HEALTH INFORMATION

With my consent Person Family Medical and Dental Center (PFMDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to PFMDC's Notice of Privacy Practices for a complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PFMDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the attention of:

Person Family Medical and Dental Center – CEO
P.O. Box 350
Roxboro, NC 27573

With my consent, PFMDC my call my home or other designated location and leave a message on my voicemail/answering machine or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, collection action regarding delinquent accounts, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, PFMDC may mail to my home or other designated location any items that assist in the practice of carrying out TPO, such as appointment reminder cards, patient statements, and miscellaneous correspondence.

With my consent, PFMDC may e-mail or facsimile transmit to my home or other designated location any items that assist in the practice of carrying out TPO, such as appointment reminder cards, patient statements, and miscellaneous correspondence. I have the right to request that PFMDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PFMDC the use of and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my consent. If I do not sign this consent, Person Family Medical and Dental Center may decline to provide treatment to me.

_____ _____

Signature of Patient/Parent/Legal Guardian **Patient's Name- Please Print**

_____ _____

Print Name of Patient/Parent/Legal Guardian **Date**

Nurse Assessment Below the age of 10

Patient Name: _____ DOB: _____ Age: _____
Place of Birth: (City)_____ and (State)_____
Medicine Allergies: _____ Food Allergies: _____

Birth History: Type of Delivery - SVD ☐ C-Section ☐
Reason: _____
APGARS: _____ @1 minute _____ @5 minutes _____
Birth Weight: _____ lbs. _____ oz. _____ gms. Birth Length: _____ in. _____ cm.
Discharge Weight: _____ lbs. _____ oz. _____ gms. Circumcision: yes ☐ no ☐
Breast Feeding ☐ Bottle Feeding ☐
Formula: _____ _____ oz. _____ QH.

Mothers Name: _____ Age:_____ Phone Number: _____
Problems with Pregnancy? _____
Drug/Etoh? _____
Problems with L/D? _____
Do your parents smoke? yes ☐ no ☐ How much? _____

Patient Medical History	History OF	Denies
ADD/ADHD		
Anemia		
Asthma		
Diabetes		
Heart Problems		
Pneumonia		
Seizures		
Sickle Cell/Thal./Anemia		
Thyroid		
Other		

Family Medical History	History OF	Denies
Asthma		
Cancer		
Diabetes		
Heart Problems		
Hepatitis		
HTN		
Seizures		
Sickle Cell/Thal./Anemia		
Thyroid		
Other		

Previous Hospitalizations: _____
_____
_____

Previous Surgeries: _____
_____
_____

Scanned ALL shot Records YES ☐ NO ☐ Date/Time Scanned: _____ Initials: _____

H/P Done By: _____ Date Done: _____

FAMILY HISTORY

Name: _____ Date of Birth: _____

List relatives (ex., mother, father, uncle) that are deceased, cause of death (if known) and approximate age at time of death.

_____
_____
_____

How many brothers do you have? _____ How many sisters do you have? _____

(Place a check mark in the appropriate columns as it applies to your family. Check all that apply.)

Health Condition	Mother/Father	Children	Brother/Sister	Aunt/Uncle	Father's Parents	Mother's Parents
Alcoholism/Drugs						
Asthma						
Cancer						
Diabetes						
Epilepsy/Convulsions						
Heart Problems						
High Blood Pressure						
Kidney Problems						
Mental Illness						
Migraines						
Stroke						
Thyroid Disease						
Other: _____						

PAST MEDICAL HISTORY

List medical conditions (diagnosis, if known) you have or have had, and how long you have had these problems (estimates will do fine). Write "none" if there are none. _____
_____
_____

List the surgeries (diagnosis, if known) you have had and when the surgeries were performed (estimates are ok). Write "none", if there are none. _____
_____
_____

Estimate when you were admitted to the hospital and for what reason you were admitted. Include important emergency room visits and severe accidents. Write "none", if there are none. _____
_____
_____