Cary Healthcare Associates, P.A.

PATIENT REGISTRATION FORMS

Name_____
Last First MI

Date of Birth: _____ Age_____ Social Security#_____

Address: _____
Street City State Zip

Mailing Address if Different: _____

Home#_____ Cell#_____ Work#_____ ext:_____

E-mail_____

Emergency Contact Person and Phone #_____

Parent's Name (If Patient is a Minor):_____

Mother: _____ Father:_____

Patient Gender: _____ Marital Status: _____ Spouse Name (If applicable) _____

Language: English Spanish Other:_____

Race and Ethnicity: (Requested per Federal Guideline) Please circle one:

Ethnicity: Hispanic Non- Hispanic

Race: American Indian or Alaska Native Asian Native Hawaiian

Black or African American White Hispanic Other

Employer and Occupation:_____

PRIMARY Insurance:_____
Policy Holders Name:_____ Date of Birth_____
SS# of Policy Holder_____ Relationship to Patient_____
Policy#_____ Group#_____ Effective Date:_____

Secondary Insurance: _____
Policy Holders Name: _____ Date of Birth_____
SS# of Policy Holder_____ Relationship to Patient_____
Policy#_____ Group#_____ Effective Date: _____

I authorize Cary Healthcare Associates to send prescriptions and retrieve medication history electronically.
Patient's Signature _____

Pharmacy Name: _____ Pharmacy#_____

Cary Healthcare Associates, PA

301 Ashville Ave. Suite 111

Cary, NC 27518

Notice of Privacy Practices

Acknowledgement

____ I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ I acknowledge that I have refused to accept a copy of the Notice of Privacy Practices.

Print Name:_____ Date:_____

Signature: _____

Signature of Patient (or authorized Representative)

Cary Healthcare Associates, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I understand that I am financially responsible for ALL charges incurred at Cary Healthcare Associates regardless of third party liability (insurance carrier).

If your insurance requires that you pay a co-pay, deductible or co-insurance you are responsible for full payment at the time of the service.

If you have no insurance, you will be required to pay in full at the time of service.

I understand that I will receive 3 statements (1 each month) for any outstanding balances, and then will be placed into collections. A $20.00 "Collection Fee" will be added to my account to cover the fees imposed to Cary Healthcare Associates by the collection agency.

CANCELLATION POLICY

I understand that a 24 hour notice is required to cancel an appointment. A **$50.00** fee will be charged when an appointment is missed without a 24 hour notice on the 1st occurrence, **$100** on the 2nd occurrence, and **$150** for any subsequent visits for the calendar year.

CARY HEALTHCARE ASSOCIATES RESERVES THE RIGHT TO DISMISS FROM THE PRACTICE ANY PATIENTS WHO FREQUENTLY MISS SCHEDULED APPOINTMENTS.

I have read and understand the above office policies and agree to accept responsibility as described.

Patient's Signature: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

CARY HEALTHCARE ASSOCIATES, PA
301 ASHVILLE AVENUE, SUITE 111 ◊ CARY, NC 27518
919-233-6000 TEL ◊ 919-233-6052 FAX

Compound Authorization for Release of Information

Federal Law states that we (Cary Healthcare Associates) cannot share your health information without your permission, except in certain situations.
Signing this form gives our office permission to share your health information with the person(s) you have indicated below.
The information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.
Payment, enrollment or eligibility benefits of your healthcare will not be affected if you sign this authorization, unless the disclosure is for eligibility or enrollment determinations.

I, _____, give permission to Cary Healthcare Associates, PA to share the following information to the listed individual(s)/health care provider(s) below:
(please check all that apply)

- ☐ All of my Healthcare Information (including lab & imaging results, medications, messages, correspondence and personal health information)
- ☐ Financial/Billing Information
- ☐ HIV/STD testing information
- ☐ Psychotherapy notes and information

Name	Relationship to patient	Phone Number (if able)

I am aware I have the right to revoke this authorization at any time if I choose I do not want Cary Healthcare Associates to continue to share my information. I authorize this authorization until I revoke in writing by completing the revocation form. *(You may obtain the revocation form from the office)*

Signature of Patient or Personal Representative: _____

Date:_____

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Adult Health Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____

Your Current Health

Medical Conditions

Please List Any Current Medical Conditions you are being treated for

Medications

Please List All Current Medications you take, Including the Dose and Frequency

Medication Name	***Dose***	***Frequency***

Allergies

Please list any Specific Drug/Environmental/Food Allergies you may have and the type of reaction. If reaction unknown please indicate so

Allergy/Reaction: _____

_____

Care Team

Please list all providers you currently see

Name of Provider	***Specialty/Location***

Vaccines

Name of Vaccine	***Date Received***
Pneumovax	
Prevnar	
Shingrix (series of 2) or Zostavax (Shingles Vaccine)	
Flu Vaccine	
TDaP (Tetnaus Vaccine)	

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Screening Test(s)

Name of Test(s)	*Date Completed*	*Result (Normal/Abnormal)*
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Eye Exam		

Surgeries

Type of Surgery	*Date of Surgery*

Family History

Please fill out who has had the following medical conditions in your family- include Mother, Father, Siblings, Grandparents, Aunts, and Uncles, Children

Condition	*Family member*
High Blood Pressure	
Heart Attack	
Stroke	
Cancer (please specify which type)	
Diabetes	
Thyroid Disorder	
Depression	
Alcohol/Substance Abuse	
Glaucoma	
Any other serious illnesses	

Social History

- ***Marital Status (please circle):*** *Single Married Divorced Widowed* ***Number of Children:*** _____

- ***Employment (please circle):***
  *Working/Occupation*_____ *Retired Disabled*

- ***Tobacco Usage (please circle):***

  Never Current Smoker Former Smoker

  Product Type: _____ *How many/day?* _____
  Year Started Smoking: _____ *Year Quit:* _____

- ***Alcohol Usage (please circle):***

  Never Rarely Occasional Moderate

  How many alcoholic beverages do you consume days/week: _____
  Type of Alcohol (beer, wine, liquor): _____

- ***Seatbelt Usage (please circle):*** *Always Sometimes Never*

- ***Exercise/Nutrition:***
  *Days/week*_____ *Types of Exercise:* _____

  Do you eat a healthy/well balanced diet: Yes No

- ***Sun Exposure (please circle):***
  Do you work regularly in the sun?: Yes No Do you wear sunscreen: Always Sometimes Never