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, P.A.

PATIENT REGISTRATION FORMS

Compound Authorization for Release of Information

Rights of the Patient

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving permission to share your health information with the person you have indicated below.

This authorization is voluntary.

Right to revoke: If you decide you do not want us to share your health information any longer you must sign a revocation form.

The information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Payment, enrollment or eligibility benefits of your healthcare will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations.

Print Name: _____ DOB: _____

I give permission to Cary Healthcare Associates, P.A. to share my health information with: (Write name and relation)

_____

_____

_____

May we leave a voicemail with information? Yes or No

Cary Healthcare Associates, P.A. may share my health information on this authorization form until this date of_____, or until I revoke the authorization in writing.

☐ All of my health care information ☐ Lab tests/ x-rays

☐ Information regarding prescription drug coverage

☐ Financial billing information

_____Date:_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach documentation)

Minor's Medical Treatment:

Child's Name: _____ Child's Date of Birth: _____

I being the parent or guardian of the above child, request and authorize any physician, nurse practitioner, or physician assistant at Cary Healthcare Associates and his/hers staff to perform all necessary medical care to my child, whether or not I am present at the appointment.

I authorize the following individuals to obtain medical care for this child, in my absence:

_____ _____

Name Relationship to Child

_____ _____

Name Relationship to Child

Signature of Parent or Guardian: _____ Date: _____

Cary Healthcare Associates, P.A.

Adult Health Questionnaire Form

Patient Name: _____ Date: _____

Date of birth: _____

Your Current Health

Please list your current medical conditions and medications you take on a regular basis.

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: _____

Other Allergies: _____

Health Maintenance

Immunizations/Screening Tests:
When did you last have the following? Please include date.
Circle results for each test.

Tdap/Td vaccination_____
Pneumovax vaccination_____
Prevnar vaccination_____
Shingles vaccination_____
Gardasil/HPV vaccination_____
Hepatitis B vaccination_____
Flu vaccination_____

Colonoscopy_____ Normal or Abnormal
PSA_____ Normal or Abnormal
Eye Exam_____ Normal or Abnormal
Stress Test_____ Normal or Abnormal
Bone Density_____ Normal or Abnormal
Sleep Study_____ Normal or Abnormal
Mammogram_____ Normal or Abnormal
Pap Smear_____ Normal or Abnormal

Medical/Surgical History:

Please list all surgeries and dates if known:

_____

_____

Please list all hospitalizations and dates if known:

_____

_____

Please list all doctors that you currently see:

_____

_____

Cary Healthcare Associates, P.A.

Adult Health Questionnaire Form

Family History:

Who in your family has had: (ex: Father, Mother, Brother, Sister, etc.)

High Blood Pressure: _____ Diabetes: _____
Heart Attack: _____ Thyroid Disease: _____
Stroke: _____ Glaucoma: _____
Cancer:(Please list what type) _____ Depression: _____
Alcohol abuse: _____
Other serious illness in the family: _____

Social History:

Marital Status: (circle one) Single Married Widowed Divorced

Do you have children? Yes or No Number: _____

Employment status (circle one) Working Retired Disabled
Occupation: _____

Do you smoke? Yes or No
If no, did you ever smoke regularly and quit? Yes or No Year Quit: _____
If yes, how many cigarettes a day do you smoke? _____
When did you start smoking?
_____

Do you drink beer, wine, or liquor? Yes or No
If yes, how many drinks per day/week? _____

Do you have or had a problem with drug abuse? Yes or No

Do you always wear a seatbelt? Yes or No

How many times a week do you exercise? _____

Do you work regularly out in the sun? _____

Advance Directives:

Do you have a Living Will? Yes or No
Do you have a Power of Attorney for healthcare? Yes or No
If yes, Name/Phone #_____

Cary Healthcare Associates, P.A.

Pediatric Health Questionnaire Form

Patients Name: _____ Date: _____

Date of birth: _____

Your Current Health

Please list any current medical conditions and medications taken on a regular basis

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: _____

Other Allergies: _____

Medical History

Please list any hospitalizations or surgeries and dates if known:

_____

Were there any significant complications during pregnancy or delivery for the child?

_____

Any recurrent illness, behavioral problems, or any problems/concerns we should be aware of and discuss?

_____

Family History:

Family Member	Name	DOB	Health Problems
Father			
Mother			
Sibling(s)			

Social History:

Does your child attend daycare or school? Yes No Is your child home schooled? Yes No

Does anyone in your home smoke? Yes No Do you have pets? Yes No What kind?

Do you have city water or well water? Yes No _____

Are you worried about your child's safety at home? Yes No

* Please bring child's current immunization record.

Cary Healthcare Associates, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES. IF YOUR INSURANCE REQUIRES THAT YOU PAY A CO-PAY, DEDUCTIBLE, OR CO-INSURANCE YOU ARE RESPONSIBLE FOR FULL PAYMENT AT TIME OF THE SERVICE.

IF YOU HAVE NO INSURANCE YOU WILL BE REQUIRED TO PAY IN FULL AT TIME OF SERVICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES REGARDLESS OF THIRD PARTY LIABILITY. (INSURANCE CARRIER)

CANCELLATION POLICY

I UNDERSTAND THAT A 24 HOURS NOTICE IS REQUIRED TO CANCEL APPOINTMENTS. PLEASE BE NOTIFIED THAT 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 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.
301 ASHVILLE AVENUE, SUITE 111, CARY, NC 27518
(919) 233-6000 FAX: (919) 233-6052

AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Birth Date (Month/Day/Year)

_____
Street Address

_____ _____
City, State, Zip Code Phone (Daytime)

At the request of the individual, I _____, do hereby authorize

_____
Name of Company/Doctor's Office

_____
Street Address City, State, Zip Code

_____
Telephone Fax number

TO RELEASE THE FOLLOWING:

_____Progress Notes
_____Specialist Correspondence
_____Hospital Reports
_____Other
_____Laboratory Reports
_____Radiology Reports
_____EKG
_____Transferred Records

_____I do _____ I do not authorize the release of information related to AIDS or HIV, psychiatric and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **CARY HEALTHCARE ASSOCIATES, P.A.**
301 ASHVILLE AVENUE, SUITE 111, CARY, NC 27518
PHONE: (919)233-6000 FAX: (919) 233-6052

PURPOSE OF DISCLOSURE:

_____Change of Doctor
_____ Referral to specialist
_____Other_____
_____Insurance
_____Personal
_____Legal Investigation
_____Workers Comp

This authorization shall be in force and effect until_____ at which time this authorization expires.

I understand I may cancel this request with written notification but it will not affect information released prior to notification of cancellation. I understand the information disclosed may be subjected to re-disclosure by the person or class of persons or facility receiving it would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

_____ _____
Signature of Individual or Guardian Date

NOTE: A processing fee may be charged. By law, maximum record copy fee is $ 0.75 per page for pages 1-25, $ 0.50 per pages 26-100 and $0.25 per pages over 100.

CARY HEALTHCARE ASSOCIATES, P.A.
301 ASHVILLE AVENUE, SUITE 111, CARY, NC 27518
(919) 233-6000 FAX: (919) 233-6052

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____
Print Patient's Full Name Birth Date (Month/Day/Year)

_____
Street Address

_____ _____
City, State, Zip Code Phone (Daytime)

At the request of the individual, I _____, do hereby authorize

INFORMATION FROM: **CARY HEALTHCARE ASSOCIATES, P.A.**
301 ASHVILLE AVENUE, SUITE 111, CARY, NC 27518
PHONE: (919)233-6000 FAX: (919) 233-6052

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_____Other

_____I do _____ I do not authorize the release of information related to AIDS or HIV, psychiatric and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO:

_____
Name of Company/Doctor's Office

_____
Street Address City, State, Zip Code

_____
Telephone Fax number

PURPOSE OF DISCLOSURE:

_____Change of Doctor _____Insurance _____Legal Investigation
_____ Referral to specialist _____Personal _____Workers Comp
_____Other_____

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