TELL US WHERE YOU HEARD ABOUT OUR PRACTICE

WHETHER YOU ARE A PATIENT THAT HAS NOT SEEN US IN SEVERAL YEARS OR A PATIENT NEW TO OUR PRACTICE; WE WANT TO KNOW WHY YOU CHOOSE US TO PROVIDE YOUR MEDICAL CARE

HAVE YOU SEEN OUR ADVERTISING AT ANY OF THE FOLLOWING LOCATIONS (PLEASE FEEL FREE TO CHECK MORE THAN ONE)

____________WORD OF MOUTH, FRIENDS/FAMILY

To whom may we thank for the referral______________________________
Names of patients will never be given but we would like to be able to thank others

____________NEWSPAPER AD OR ARTICLE

____________ATHLETIC EVENTS/BANNERS/PROGRAM SPONSHORSHIPS

____________PHONE BOOK

____________CHATUGE WEBSITE (WWW.CHATUGEFP.ORG)

____________ER OR HOSPITAL FOLLOW UP/REFERRAL

____________FACEBOOK OR OTHER SOCIAL MEDIA WEBSITE

____________OTHER ____

For Demographic purposes please list your AGE: ______________________

Chatuge Family Practice

REGISTRATION FORM

(Please Print on line below question)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Cell phone no.:	**E-Mail Address:**	Preferred Pharmacy:
( )		

Race:	Ethnicity:	Preferred Language:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:		Address (if different):	Home phone no.:
	/ /			( )
Is this person a patient here?	❑ Yes	❑ No		

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No			
Please indicate primary insurance	❑ Medicare	❑ NC Medicaid	❑ Blue Cross Blue Shield	❑ United Healthcare	❑ Aetna
❑ Cigna Healthcare	❑ Crescent Network	❑ Medcost Network	❑ Medicare Alternative (PFFS)	❑ Other	❑ NC Health Choice

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chatuge Family Practice or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

Chatuge Family Practice

Patient Consent to the Use and Disclosure of Health Information
For the Treatment, Payment, or Healthcare Operations

I, ________________, understand that as part of my health care, Chatuge Family Practice maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnose, treatment, and any plans for future care or medical treatment. This record is also used as a source for applying coding information for my account.

I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to restrict the use of my health information regarding any disclosure to carry out treatment, payment, or other health care operations.

I understand that Chatuge Family Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations and would be unable to bill any insurance carrier.

I further understand that Chatuge Family Practice reserves the right to change their Notice of Information Practices and prior to the implantation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Chatuge Family Practice change their notice, they will notify me accordingly by an updated notice when I revisit the office.

In my absence, I authorize Chatuge Family Practice to discuss my health information or account information with:
(list names of spouse, children (over the age of 18), friends, relatives, etc.)
Your information cannot be discussed with anyone NOT on this list.

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other physicians, laboratories, insurance companies, or other entities, in regards to my medical care and collection of payment for services rendered. I consent to such disclosures for these permitted uses, including disclosures via fax. I authorize Chatuge Family Practice to leave messages that will identify the caller and the office they are calling from on an answering machine that I provided. Please note that medical information will not be left on the machine. In your absence, a message will be left to call the office back to obtain this information.

I understand and accept the terms of this consent.

______________________________ ______________________________

Patient/Parent/Guardian/POA Signature Date

Chatuge Family Practice
241 Church Street; PO Box 1309
Hayesville, NC 28904
(828) 389-6383

PATIENT FINANCIAL POLICY

Thank you for choosing Chatuge Family Practice as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

1. All charges are due at the time of service. If an emergency arises or if you are unable to pay in full at the time you are seen, prior arrangements should be made with our billing department.
2. We will gladly file your insurance for you under most circumstances; we will need current and up to date information on your insurance plan. It will be your responsibility to verify if our practice participates with your insurance. This is required at the time of your appointment; otherwise you will be responsible for the full charges.
3. If **your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it**. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.
4. Charges for all hospital and emergency visits will be filed with most insurances companies. If the insurance company has not responded within 60 days of our filing, the charges will be sent to you directly and you will be responsible for them as well as any other charges.
5. Charges for services rendered to children of divorced parents will be the responsibility of the parent who seeks treatment for that child. Charges will be due at the time of service regardless of any court order.
6. The charge for a returned check is $35 payable by cash, credit card or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.
7. You are required to give a 24 hour notice of any appointments that you will be unable to keep. Failure to do this will result in a $30.00 no show charge. This charge will have to be paid before another appointment can be scheduled for you. After three (3) no show appointments you will be terminated from our practice.
8. There will be a minimum charge of $10.00, payable in advance for medical records you request. Fees may be higher depending on the size of the medical record.
9. If you are a MAP patient, you are required to pay your co pay at the time of service.
10. If you have an old balance with our practice, you will be required to pay the balance in full before we can schedule another appointment for you.

Patient Signature ____________________ Date ____________________

Chatuge Family Practice
241 Church Street; PO Box 1309; Hayesville, NC 28904
Phone: (828) 389-6383 Fax: (828) 389-6803
www.chatugefp.org

Patient Consent for Electronic Prescribing

Chatuge Family Practice has implemented e-prescribing as part of an on-going effort to improve your health care. E-prescribing refers to a system used to submit prescriptions electronically to your pharmacy.

By signing below, you provide your consent for Chatuge Family Practice and its providers to electronically submit your prescriptions through the e-prescribing system described above and to request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

This consent will remain in effect until you withdraw it. You may withdraw your consent at any time except to the extent it has already been relied upon. Your decision not to sign this form will not affect your ability to receive medical care or your ability to receive your prescriptions through alternative means.

Patient Name:____________________________________

Patient or Guardian Signature: __________________________

Relationship to Patient (for guardian signatures): ____________ **Date:** __________

Notice of Medical Treatment

By signing below I acknowledge that Chatuge Family Practice will not prescribe narcotics (Percocet, Norco, Vicodin, etc.) or other pain medications to me. I understand they will not prescribe benzodiazepine's (i.e... Xanax, Ativan, Valium, etc.) or antipsychotics. I understand to receive these medications I will need to find a separate provider.

I also agree to let my provider at Chatuge Family Practice know if I am prescribed these medications by an outside Provider.

____

Patient Name: **Date:**

____

Patient Signature

ORIGINAL DATE:	3/1/2012
UPDATED	12/04/2015

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

NAME *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
MARITAL STATUS:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
PREVIOUS OR REFERRING DOCTOR:	**DATE OF LAST PHYSICAL EXAM:**	

Medical Problems (any problem you take a medication for regularly or occasionally)

(*Example*: Hypertension, Hyperlipidemia, Asthma,)

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

# of meals you eat in an average day?

Rank salt intake ☐ Hi ☐ Med ☐ Low

Rank fat intake ☐ Hi ☐ Med ☐ Low

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola

# of cups/cans per day?

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind?

How many drinks per week?

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day

☐ # of years ☐ Or year quit

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex			
	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness indude intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			*Children*	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

Number of pregnancies Number of live births

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Have you had a D&C, hysterectomy, or Cesarean? ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Any problems with control of urination? ☐ Yes ☐ No

Any hot flashes or sweating at night? ☐ Yes ☐ No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Yes ☐ No

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No

Date of last pap and rectal exam?

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No

If yes, # of times

Do you feel pain or burning with urination? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Do you feel burning discharge from penis? ☐ Yes ☐ No

Has the force of your urination decreased? ☐ Yes ☐ No

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Yes ☐ No

Do you have any problems emptying your bladder completely? ☐ Yes ☐ No

Any difficulty with erection or ejaculation? ☐ Yes ☐ No

Any testicle pain or swelling? ☐ Yes ☐ No

Date of last prostate and rectal exam?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- ☐ Skin
- ☐ Head/Neck
- ☐ Ears
- ☐ Nose
- ☐ Throat
- ☐ Lungs
- ☐ Chest/Heart
- ☐ Back
- ☐ Intestinal
- ☐ Bladder
- ☐ Bowel
- ☐ Circulation
- ☐ Recent changes in:
- ☐ Weight
- ☐ Energy level
- ☐ Ability to sleep
- ☐ Other pain/discomfort: