CAROLINA PHYSICIANS GROUP

7615 COLONY ROAD, SUITE 115 CHARLOTTE, NC 28226
Tel (704) 378 4357
Fax (704) 378 6441

REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

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

Home Phone: _____ Alternative#: _____	DL/ID #: State: NC /	Social Security #:	Birth date / /	Age	Sex ☐M ☐F

Street Address:	City:	State:	Zip:

Employer / Occupation:	Employer Address:	Employer phone #:

Chose this practice, because/referred by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow pages	☐ Other_____
Estimate of Gross Income ? $_____	☐ Weekly	☐ Biweekly	☐ Monthly	☐ Yearly	Family size: _____

RESPONSIBLE PARTY INFORMATION

Last name: First: Middle:	Birth date: / /	Address(If different): City: State: Zip

Home Phone:	DL/ ID NUMBER:	State:	SS#:
Employer/Occupation:	Employer Address:		Employer phone #:

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No	If "Yes" Please indicate primary Insurance:				
Insured's name:	Insured's S. S #:	Birth date / /	Group # :	Policy # :	Co-payment $

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

Name of secondary insurance (if applicable):	Insured's name:	Group # :	Policy # :

INCASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I, the undersigned, do voluntarily consent to outpatient care with Carolina Physicians Group and consent to the performance of examinations and procedures by medical staff and associates. I also authorize Carolina Physicians Group to release all medical information required to receive payments for services billed to Medicare, Medicaid, or private insurance(s).
I understand that I am financially responsible for all services and charges that are not covered benefits of my insurance. I may elect to continue services that not covered by my insurance carrier, but I understand that it will be at my own expense. I authorize my insurance benefits be paid directly to Carolina Physicians Group.
This authorization and assignment is a permanent one-time signature, which will remain on file and will be used for future claims. I may revoke it at any time by written notice.

*Patient/Guardian signature:*_____ *Date:*_____

FAMILY HISTORY

Please indicate with a check mark if you or family members have or have had any of the following conditions

	Self	Mom	Dad	Sister	Brother	Uncle/Aunt
Diabetes (not on insulin)						
Diabetes (on insulin)						
High Blood Pressure						
High Cholesterol						
Over weight/Obesity						
Heart Attack / Heart Disease						
Kidney Disease						
Tobacco abuse						
Stroke						
Cancer, Breast						
Cancer, Colon						
Cancer, Ovary						
Cancer, Other _____						
Depression / Other Psychiatric illness						
Alcoholism						
Substance Abuse						
Anemia / Blood Disorder						
Bleeding Problem						
Glaucoma						
Thyroid disorder						
Mental Retardation or Learning Disability						
Tuberculosis						
Immune Disorder						
Genetic Disorder						
Congenital Anomaly/Birth Defect						
Other _____						

Patient Name: _____

Patient / Responsible Party Signature: _____ Date:_____

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Past Medical History
Please describe any major medical problems and their dates:

_____
_____
_____

Hospitalizations/operations (with dates):

_____
_____
_____

Broken bones, or severe sprains:

_____
_____
_____

SOCIAL HISTORY
Tobacco Use
Cigarettes: Never
Current smoke: # packs a day_____ # of years_____
Quit date _____
Other tobacco: Pipe Cigar Snuff Chew
Alcohol Use
Do you drink alcohol? No Yes
# of drinks per week _____
Is your alcohol use a concern for you or others?
Yes No

_____
Drug Use

_____
Do you use any recreational drugs?
Yes No
Have you ever used needles or injected drugs?
Yes No

Sexual Activity
Sexually Active? Yes No
Current sex partner(s) are: Male Female
Have you ever had any sexually transmitted diseases (STD's?) Yes No

Other Concerns
Caffeine Intake: # cups per day (coffee/tea/soda) ____
None
Weight/Diet
Are you satisfied with your weight? Yes No
Do you eat or drink 4 servings of dairy, soy, or take a calcium supplement daily? Yes No

Exercise:
How often do you exercise? Daily Frequently Occasionally Never
Safety:
Do you use seatbelts? Daily Frequently Occasionally Never
Is VIOLENCE at home a concern for you?
Yes No

Exposure:
Have you ever been exposed to any of the following?
Chemicals, cleaning fluids, oils, etc.
Loud Noise
Asbestos
X-ray or radio active materials

SOCIOECONOMICS
Occupation:

Employer:

Years of education/highest degree

_____

Marital Status: Single Partner/Married Divorced Widowed Separated

Spouse/Partner's Name:

_____
Number of children/ages: _____
Who lives at home with you? _____

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Patient Health History Form

NAME:_____ DATE OF BIRTH_____ AGE:_____

Previous Doctor_____ Phone Number_____

ALLERGIES OR REACTIONS TO MEDCINES
Please list any medications to which you are allergic or which you are unable to take for any reason

_____

_____

MEDICATIONS
Please list any prescription and non-prescription medicines Vitamins, home remedies, birth control, etc.

Medication Dose How many times per day

_____

_____

_____

_____

_____

HEALTH MAINTENANCE SCREENING TEST
Have you received any of the following test or examinations?

Lipid (cholesterol)	Yes	No
Colonoscopy	Yes	No
EKG	Yes	No
Eye Exam	Yes	No
Chest X-ray	Yes	No
Dental Exam	Yes	No

IMMUNIZATIONS
Have you received any of the following immunizations?

Tetanus (TD)	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Influenza	Yes	No
Rubella	Yes	No
Pneumovax (pneumonia)	Yes	No
Varicella (chicken pox shot or illness)	Yes	No
Human papillomavirus (HPV)	Yes	No

WOMEN HEALTH HISTORY
# of pregnancies _____ # of deliveries _____
# of miscarriages_____ # of abortions _____

Mammogram No Yes Date:_____
Abnormal Mammogram No Yes Date:_____
If yes, what was the abnormality?

_____

Pap Smear No Yes Date:_____
Abnormal Pap? No Yes
If yes, what was the abnormality?

_____

_____

How old were you when you went through menopause?

_____

MEN'S HEALTH HISTORY
PSA (prostate exam) No Yes Date:_____
Abnormal? No Yes Date:_____
If yes, what was the abnormality?

_____

_____

Colon Exam Yes No Date: _____
(colonoscopy)
Abnormal? Yes No Date: _____

If yes, what was the abnormality?

_____

_____

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CONSENT TO USE OR DESCLOSE INFORMATION FOR TREATEMENT, PAYMENT OR HEALTH CARE OPERATIONS

I_____ hereby consent to the use or disclosure of individually identifiable health information ("protected health information") by Doctor Jay Fernando, in order to carry out my treatment, payment, or health care operations. I have reviewed Doctor Fernando's "Notice of Privacy Practices for Protected Health information," for a more complete description of the potential uses and disclosures of such information, prior to signing this consent form.

Doctor Fernando reserves the right to change the terms of his Notice of Privacy Practices for Protected Health Information at any time. If he does change the terms of his Notice of Privacy Practices, I may obtain a copy of the revised Notice from any staff member.

I retain the right to request that Doctor Fernando further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Doctor Fernando is not required to agree to such requested restrictions; however, if he does agree to my requested restriction(s), such restrictions are then binding on Doctor Fernando and his staff.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Doctor Fernando in writing. The revocation shall be effective except to the extent that Doctor Fernando has already taken action in reliance on the Consent.

Doctor Fernando may refuse to treat me if I (or an authorized representative) do not sign this Consent Form (except the extent that Doctor Fernando is required by law to treat individuals.) If I (or authorized representative) sign this Consent Form and then revoke consent, Doctor Fernando has the tight to refuse to provide further treatment to me as of the time of revocation (except to the extent that Doctor Fernando is required by law to treat individuals.)

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED AN OUTLINE OF "THE NOTICE OF PRIVACY," I AM THE PATAIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____ _____
Signature of Patient

_____ _____
Person Signing on behalf of Patient* Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

_____
_____
_____

_____
Signature of Witness