

PATIENT INFORMATION

DATE: \_\_\_\_\_ CHART #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MIDDLE MAIDEN

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ ext. \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Responsible Party:  Self  Spouse  Child  Legal Guardian

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Employer Name: \_\_\_\_\_ Employment Status:  Full-time  Part-time

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Student:  Full-time  Part-time

Parents: (if patient is a minor) Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN PATIENT

Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ ext. \_\_\_\_\_ DOB: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Social Security #: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employment Status:  Full-time  Part-time

INSURANCE INFORMATION

INSURANCE ONE

Policyholder's Name (as it appears on card): \_\_\_\_\_ Policyholder's #: \_\_\_\_\_

Name of Plan: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Address to Mail Claims: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

INSURANCE TWO

Policyholder's Name (as it appears on card): \_\_\_\_\_ Policyholder's #: \_\_\_\_\_

Name of Plan: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Address to Mail Claims: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

INSURANCE THREE

Policyholder's Name (as it appears on card): \_\_\_\_\_ Policyholder's #: \_\_\_\_\_

Name of Plan: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Address to Mail Claims: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ ext. \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



**Carolinus Medical Center  
NorthEast**

**AUTHORIZATION FOR TREATMENT:** The undersigned hereby applies for outpatient treatment and/or admission of the patient to Carolinus Medical Center-NorthEast and give permission to the physician in charge of the patient's care to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatment or examination in this hospital. I understand that students or residents in various health-related training programs may participate in my care or observe special procedures.

**RELEASE OF INFORMATION:** The undersigned authorizes CMC-NorthEast to disclose all or any parts of the patient's medical record to any of the following: listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning worker's compensation case, any review agency which conducts reviews of hospital utilization under an agreement with the patient's employer or other payment source, and any health care organization, healthcare provider or agency needing medical information to assist in the patient's continuing care. The disclosed medical record may include information regarding the treatment of psychiatric and drug and alcohol abuse conditions, information concerning AIDS, AIDS-related conditions or HIV status. CMC-NorthEast will make every effort to pre-certify and/or pre-authorize treatment with third party payors who conduct Utilization Review as a service to patients; however, CMC-NorthEast does not accept responsibility for lack of pre-certification and/or preauthorization and is not responsible for the final payment outcomes or timing restraints. I further agree to have my name, date of birth, and physician's name posted outside my door and on unit assignment boards for identification purposes. I also understand that I may revoke this authorization by providing written notice to the hospital.

**MEDICARE/TRICARE, MEDICAID PATIENT'S INFORMATION:** I certify that the information I have given in applying for payment under Title V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I understand that the health care services paid for under Medicare, Medicaid and Maternal and Child Health Programs are subject to review by the Professional Review Organization. I authorize CMC-NorthEast and the applicable County Department of Social Services (e.g., Cabarrus, Mecklenburg, Rowan, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. This information may include the following: date of application, application status, the reason my application remains pending, any verification required to complete my application, the date and reason of denial (if applicable). I have received the document titled "An Important Message from TRICARE" or "Medicare" at the time of my admission. My signature only acknowledges my receipt of this message from CMC-NorthEast and does not waive any of my rights to request a review or make me liable for any payment.

**ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS:** I hereby authorize payment directly to CMC-NorthEast and all physicians involved in my treatment or diagnosis at CMC-NorthEast by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of hospitalization or Outpatient Services of the below named patient. I unconditionally assign any insurance benefits to CMC-NorthEast and all physicians involved in my treatment and further authorize both to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

**INDEPENDENT CONTRACTORS:** I understand that many physicians (and their assistants) providing care at CMC-NorthEast are independent contractors and NOT CMC-NorthEast employees. I consent to care by these non-employees. I understand that I will receive a separate bill for all physician (and assistants) services provided to me.

**PERSONAL VALUABLES:** I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

Signature of Patient (or legally authorized representative):	Date	Signature of Guarantor (or responsible party):	Date
Relationship to patient:		Relationship to patient:	
Witness:		Patient is a minor of _____ years of age or is unable to sign because: _____	

**TELEPHONE CONSENT FOR TREATMENT**

Name/Title of 2 Persons Witnessing Consent: _____ _____	Date	Person Called:  Relationship to patient:
	Time	
Consent Granted: Yes _____ No _____	Remarks:	



Carolinan Physicians Network  
Carolinan HealthCare System

**ACKNOWLEDGEMENT FORM**

Medical Records # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Authorized Representative)

Relationship to Patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

Reason Patient Unable/Unwilling to Sign: \_\_\_\_\_

**ACKNOWLEDGEMENT FORM**  
**DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK**

Numero de Registro Medico \_\_\_\_\_

Nombre del Paciente \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_/\_\_\_\_/\_\_\_\_  
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente o Representante Autorizado)

Relacion al Paciente: \_\_\_\_\_ Mismo \_\_\_\_\_ Esposo (a) \_\_\_\_\_ Otro \_\_\_\_\_

Razon Por la Cual El Paciente No Puede/No Desea Firmar: \_\_\_\_\_

# Pediatric Patient History

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: male female

Mother \_\_\_\_\_ Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Father \_\_\_\_\_ Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Legal Guardian (if other than parent) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Siblings (names and birthdates) \_\_\_\_\_

Parents are: Married \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
Pets (Describe) \_\_\_\_\_ Smokers in the home (who) \_\_\_\_\_  
Firearms in House? Yes No Smoke Detectors in the house? Yes No  
Water fluoridated? Yes No Diet \_\_\_\_\_  
Does child attend daycare? Yes No Religious Preference: \_\_\_\_\_

**ALLERGIES** (Drugs, Food, Environment) \_\_\_\_\_

## BIRTH HISTORY

Length of pregnancy \_\_\_\_\_ Type of delivery: vaginal c-section  
Weight \_\_\_\_\_ Length \_\_\_\_\_  
Type of feeding: breast formula (name) \_\_\_\_\_  
Complications during pregnancy, labor or delivery \_\_\_\_\_  
Problems in Nursery \_\_\_\_\_

## DEVELOPMENT

At what age did the child first:  
Roll over \_\_\_\_\_ Sit alone \_\_\_\_\_ Speak single words \_\_\_\_\_  
Crawl \_\_\_\_\_ Walk alone \_\_\_\_\_ Make sentences \_\_\_\_\_  
Toilet train \_\_\_\_\_

Did the child have any of the following problems during the first few months of life? (check if yes)

Jaundice \_\_\_\_\_ Anemia \_\_\_\_\_ Breathing difficulties \_\_\_\_\_  
Trouble feeding \_\_\_\_\_ Seizures \_\_\_\_\_ Blue spells \_\_\_\_\_  
Severe colic \_\_\_\_\_ Infections \_\_\_\_\_ Required oxygen \_\_\_\_\_

## CHILDHOOD ILLNESSES

Has the child had any of the following? (check if yes)  
Chicken pox \_\_\_\_\_ Meningitis \_\_\_\_\_ Tubes in ears \_\_\_\_\_ Pneumonia \_\_\_\_\_  
Asthma/wheezing \_\_\_\_\_ Seizure \_\_\_\_\_ Heart murmur \_\_\_\_\_ Frequent ear infections \_\_\_\_\_  
Other chronic or ongoing medical problems \_\_\_\_\_

**HOSPITALIZATIONS** ( for surgery, accidents, or injuries). List date and reason for hospitalization

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS** List all including vitamins, fluoride, iron, prescription, non-prescription drugs, and herbs.

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**FAMILY HISTORY** Do any of the child's close relatives (parents, grandparents, brothers or sisters) have any of the following? (check if yes)

High blood pressure  
Heart disease  
Sickle cell  
Cancer

Diabetes  
Bleeding disorder  
Cystic Fibrosis  
Mental problems

Allergies  
Asthma  
Alcoholism

Seizures  
Kidney disease  
High cholesterol

**IMMUNIZATIONS** Please provide us with a current list of all immunizations received.

DOES THE CHILD HAVE ANY UNUSUAL PROBLEM WITH (check if yes)

Behavior  
Discipline  
Breath holding  
Hyperactivity

Temper tantrums  
Vision  
Speech  
Thumbsucking

Nightmares  
Bedwetting  
Toilet training

Trouble in school  
Learning Difficulty  
Attention Deficit

WHAT RECENT PROBLEMS HAS THE CHILD HAD? \_\_\_\_\_

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WHAT CONCERNS DO YOU HAVE TODAY? \_\_\_\_\_

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## Review Of Systems Questionnaire

Have you been feeling any of these symptoms today?

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Today's Date:

Constitutional	Yes	No	*	Chest	Yes	No
Feeling tired or poorly			*	Difficulty swallowing		
Fever (as symptom)			*	A cough		
Chills (as symptom)			*	Shortness of breath		
Recent weight loss(lbs )			*	Palpitations		
Recent weight gain(lbs )			*	Chest pain or discomfort		

Ear, Nose, Throat	Yes	No	*	Hemo/Endocrine	Yes	No
Nasal congestion			*	An easy bruising tendency		
Post-nasal drip			*	Excessive sweating		
Sore throat			*	Sweating heavily at night		
Earache (right)			*	Excessive thirst		
Earache (left)			*	Temperature intolerance		

Urinary	Yes	No	*	Neuro/Eyes	Yes	No
Pain during urination			*	Headache		
Increased urination			*	Dizziness		
Blood in urine			*	Ringing in ears		
Urinating more than 1 x night			*	Numbness		
			*	Decrease in strength		
			*	Red Eyes		
			*	Sleep disturbances		
			*	Depression		
			*	Anxiety		

GI	Yes	No	*	Gynecological (women)	Yes	No
Decreased appetite			*	Unexplained vaginal bleeding		
Abdominal Pain			*	Vaginal discharge		
Nausea			*	Vaginal pain		
Vomiting			*	Vaginal itching or burning		
Diarrhea			*			
Constipation			*			
Heartburn			*			
Blood in stool			*			

Skin/Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		



One patient per authorization form

Carolinus HealthCare System

There may be a charge for record copies.

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: [ ] Ongoing Communication [ ] Copy of Record [ ] Legal or Insurance Review [ ] Authorized Representative's Request [ ] Other

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information: Facility/Practice Name: Telephone #: Facility/Practice Address: Fax #: The facility/practice/individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): From: (MM/DD/YY) To: (MM/DD/YY)

CHECK THE SPECIFIC INFORMATION TO BE RELEASED: [ ] All Records & Details [ ] Discharge Summary [ ] Lab/Pathology Reports [ ] Physician's Orders [ ] Other (Please Specify) [ ] Appointment Information [ ] Emergency Room Records [ ] Medication Records [ ] Progress Notes [ ] Billing Information [ ] History & Physical [ ] Office/Clinic Notes [ ] Psychiatric Evaluation [ ] Consultation Report [ ] Immunization Records [ ] Operative Report [ ] Radiology/Imaging Reports [ ] Test Results I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED: Patient Name: Patient Address: Social Security #: Date of Birth: Medical Record/Chart # Please provide phone numbers where you are authorizing CHS to leave patient information as described above: Home: Work: Cell:

RELEASE TO: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below: Name Address Telephone/Fax # Relationship

PATIENT'S RIGHTS AND SIGNATURE: I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.) I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization. I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy. This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document. If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization. PRINT NAME (Patient/Authorized Representative): SIGNATURE: DATE: If Authorized Representative, please indicate relationship to patient: [ ] Spouse [ ] Parent [ ] Guardian [ ] Executor of Estate [ ] Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and/or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of 18, the patient must also sign this authorization. NAME OF MINOR: SIGNATURE OF MINOR: DATE:

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? [ ] Yes [ ] No [ ] N/A

For Carolinus HealthCare System Use Only: CHS Employees Please Complete [ ] Identification verified [ ] Copy of Authorization given to patient Date of release: via [ ] Mail [ ] Fax [ ] Other [ ] Accepted - Released information as described above [ ] Partially Accepted - Describe patient information not released: Employee Name & Title Employee Signature: Date: