Whole Heart Family Medicine

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# NEW PATIENT REGISTRATION FORM

First name: _____

Last name: _____

Preferred name: _____ Sex: Male Female Race: _____

Date of Birth: _____ Age: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (CELL): _____ (HOME): _____ (WORK): _____

Email: _____

By providing us with your e-mail address, you authorize Whole Heart Family Medicine to send you periodic reminders or announcements. In addition, you will be given access to an online portal where you can access your medical records and contact the office via email for appointments, refill requests, etc. We will not disclose your email address to any third party. You may terminate receiving e-mails from us at any time.

*Would you like your e-mail to be added to our Whole Heart Family Medicine subscriber list, which will include a short monthly video blog or newsletter with practical tips and the latest information on health and wellness? YES _____ NO _____

Emergency Contact _____ Relationship _____
Phone _____

**How did you hear about our practice?**

- ❑ I am a Previous Patient
- ❑ A Friend – Who? _____
- ❑ Medical Office Referral – Who? _____
- ❑ Website – wholeheartfamilymed.com
- ❑ Facebook/Instagram/Twitter
- ❑ Billboard
- ❑ Pamphlet
- ❑ Other: _____

**PRIMARY Health Insurance:** _____

**SECONDARY Health Insurance:** _____

*IF the patient is not the policy holder, please indicate their relationship: SPOUSE _____ CHILD _____
*Name of policy holder IF different from patient _____ Date of birth: _____

**Local Pharmacy (name/address)** _____ **#** _____
**Mail order pharmacy?** _____
**Which do you prefer?** 30 day prescriptions _____ 90 day prescriptions _____

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What is the reason for your visit today? Establish medical care _____ Other _____

**CURRENT MEDICAL PROBLEMS FOR WHICH YOU ARE TREATED** (i.e. High blood pressure/ cholesterol, diabetes, thyroid disease, anxiety, sleep apnea, asthma, joint pain, reflux, etc.)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

**PAST MEDICAL HISTORY** (Previous illnesses - i.e. heart attacks, cancers, blood clots, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

| **PAST SURGICAL HISTORY** | **Date** | **By Whom?** |
|---|---|---|
| Check here if you have never had surgery ____ | | |
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

*If over 50, have you had a colonoscopy? Yes No Date of last colonoscopy _____ By Whom? _____
When was your last physical? _____ By Whom? _____

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**FAMILY HISTORY** – (especially parents & siblings)

*(list family members with heart disease, strokes, cancers, autoimmune disease, or other serious illnesses) _____ Check here if parents and siblings have had no major health problems or disabilities.

| | Deceased? | Age when Died? | Cause of Death? | SIGNIFICANT MEDICAL PROBLEMS? |
|---|---|---|---|---|
| Mother | No __ Yes __ | _____ | _____ | _____ |
| Father | No __ Yes __ | _____ | _____ | _____ |
| Brother | No __ Yes __ | _____ | _____ | _____ |
| Sister | No __ Yes __ | _____ | _____ | _____ |

Other _____

**ALLERGIES** (CIRCLE all that apply and list what type of reaction you had to each, i.e. rash)

CHECK HERE IF NO KNOWN ALLERGIES _____

Penicillin _____ Codeine _____ Sulfa Drugs _____ Erythromycin _____

Latex _____ Adhesive Tape _____ Other _____

**SOCIAL HISTORY**

**Marital status?** married single divorced separated widowed

**Children?** No Yes **How many?** ____

**Do you smoke cigarettes?** NEVER YES/DAILY YES/OCCASIONALLY I QUIT Year you quit? _____

Total years of smoking? ____ Packs per day smoked (current or previous) _____ Ecigs/vape? YES NO I QUIT

**Do you smoke Marijuana or take any illegal drugs?** NO YES I QUI

**Which drugs?** _____ **How often?** _____

**Do you drink alcohol?** NO YES OCCASIONALLY DAILY

**How many drinks a week?** _____ **Occupation** _____

**Special diet?** _____ **Do you exercise?** YES NO **What type?**_____

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| NAME of your other medical providers | What Type of specialist? (cardiologist, orthopedic . . .) |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

| Current Prescription Medication | Dose | Taken how? (1 or 2x day?) | 90 day script? (YES/NO) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**MEDS (continued) Vitamins/Supplements/Over the Counter Medications**

| | | |
|---|---|---|
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |
| 16. | | |
| 17. | | |
| 18. | | |
| 19. | | |
| 20. | | |

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# HIPAA RELEASE FORM

Authorization for Use or Disclosure of Protected Health Information

**I authorize the release of information including: diagnosis, records, medications, examination rendered to me, claims information, etc.**

This information may be released to:

___ Spouse _____ #_____

___ Child(ren) _____ #_____

___ Other _____ #_____

*You have the right to revoke this authorization at any time in writing.

**For phone messages - please call:**

___ My cell number ___ My home number ___ Other:_____

*Information will not be discussed with any unauthorized person who may answer the phone

**If unable to reach me:**

___ You may leave a detailed message

___ Please leave a message asking me to return your call

___ Do not leave a message

**My preferred method(s) of contact for communication: (check all that apply)**

For appointment reminders: ____ Text ____ Phone ____ Email

For health notifications, announcements, & billing: ____ Text ____ Phone ____ Email

*By signing this form, I agree to receive automated phone calls or texts regarding appointment reminders, etc. However, I have the right to refuse to sign this authorization - treatment by any party may not be conditioned upon my signing of this authorization.

Signature: _____ Date: _____

Print Name: _____

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# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed

**I, _____, hereby give my consent for Whole Heart Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).**

By signing this form, I authorize the release of my complete health record (list if there are any exceptions - please specify): _____

This authorization for release of information covers all past, present, and future periods of healthcare (UNLESS other dates are specified here: _____)

A full copy of Whole Heart Family Medicine's "Notice of Privacy Practices" is available at the front desk and will be furnished to me upon my request. I have the right to review the Notice of Privacy Practices prior to signing this consent. Whole Heart Family Medicine reserves the right to revise its Notice of Privacy Practices at any time.

**MY RIGHTS:**

- I have the right to request that Whole Heart Family Medicine restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to allow Whole Heart Family Medicine to use and disclose my PHI to carry out TPO.
- I understand that I have the right to revoke this authorization at any time in writing, except where uses or disclosures have already been made based upon my original permission.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization.
- At my request, I will be given a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient or Guardian: _____ Date: _____

Print Patient's Name: _____

Print Name of Legal Guardian or Representative (if applicable): _____

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# FINANCIAL POLICY

Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this, we ask that you adhere to the following guidelines.

- I agree to furnish Whole Heart Family Medicine with a copy of my current health insurance card(s) and contact the office right away if there is any change.
- I authorize the release of medical information necessary to process my insurance claims and I assign insurance benefits to Whole Heart Family Medicine for services provided to me by Whole Heart Family Medicine health care providers.
- I understand that copays are due at the time of service, as required by my insurance company, on the same day of the appointment at Whole Heart Family Medicine.
- Uninsured patients are offered a discounted rate but agree to pay their bill in full on the day they are seen. They will also be responsible for any additional charges that are incurred during their office visit (lab tests, injections, etc.)
- I accept full financial responsibility for all charges, insurance balances, self-pay balances and other fees that may not be covered by my medical plan.
- I understand that my account will be charged $50 when a check I presented for payment is returned and marked “non-sufficient funds” (NSF).
- I understand that if I do not show up for my appointment, or if I cancel my appointment with less than 24 hours’ notice, I will be charged $50. The rationale for this policy is to encourage patients to give ample notice of any schedule changes so we can offer their appointment time to other patients who need to be seen that day.
- In the event I am unable to pay my bill in full, I will contact the office to discuss financial arrangements.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by Whole Heart Family Medicine.

Patient Signature (Guarantor): _____ Date: _____

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## Carey McNamara PA-C
## MEDICAL RECORDS RELEASE FORM

TO: _____

FAX # _____ Phone # _____

FROM: Whole Heart Family Medicine _____

Fax # (843) 654-1260_____ Phone # (843) 637-4173_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or record of my protected health information to the following physician/person/facility/entity and/or those directly associated with my medical care at:

Whole Heart Family Medicine

2891 Tricom Street Suite C

North Charleston, SC 29406

**PHONE** (843) 637-4173

**FAX** (843) 654-1260

The information you may release is as follows: (check)

___ Complete Records

___ Please be sure to include ALL lab results, diagnostic testing such as last mammogram & DEXA, last colonoscopy & eye exam, xray/MRI results, sleep study results, vaccine record, and consult notes from other specialists

___ Other (explain) _____

The purpose/reason for this release of information is as follows: (check)

___ Transfer my medical care to new office (continuity of care)

___ Other (explain) _____

Patient Name: _____ Date of Birth: _____

Signature _____ Date _____