New Patient Packet

Name:____

Phone:________________________ DOB:________________

Please note that we do access the North Carolina Controlled Substances Reporting System (CSRS) on a regular basis. This statewide reporting system was established by North Carolina law to improve the state's ability to identify people who abuse and misuse prescription drugs classified as schedule II-V controlled substances. It is also meant to assist clinicians in identifying and referring for treatment patients misusing controlled substances. The N.C. Commission for, and the Division of, Mental Health, Development Disabilities and Substance Abuse Services make rules and manage the program.

Hugh Chatham Women's Center complies and reports the use of controlled substances reporting system when prescribing controlled substances.

OFFICIAL USE ONLY

- ☐ Yes, next available appointment.
- ☐ Yes, needs to be seen ASAP.
- ☐ No. The individual would be better served staying with their current physician or finding another doctor.
- ☐ No. Other:________________________________

____

____

____

____

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital

New Patient Form

Please complete all information. Please bring insurance card with you to your appointment.

LAST NAME	FIRST NAME	MIDDLE	PREFERRED NAME
MAIDEN NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RACE
MARITAL STATUS	DRIVER'S LICENSE #	PREFERRED LANGUAGE	ETHNICITY

Primary Care Physician: ______________________________

Home Address: ______________________ City: ______________________ Zip: __________

Phone Numbers: ______________ HOME ______________ WORK ______________ CELL

Preferred Method of Communication: ______________________________

EMERGENCY CONTACT PERSON	RELATIONSHIP
EMERGENCY CONTACT HOME PHONE	CELL PHONE

Other Information

PATIENT'S EMPLOYER	FULL/PART TIME	OCCUPATION	HIRE DATE
INSURANCE POLICY HOLDER'S NAME	POLICY HOLDER'S DATE OF BIRTH	RELATIONSHIP	PHONE
POLICY HOLDER'S SSN	POLICY HOLDER'S EMPLOYER	WORK PHONE	

Insurance Information

PRIMARY INSURANCE CARRIER	POLICY HOLDER	POLICY NUMBER	GROUP NUMBER
SECONDARY INSURANCE CARRIER	POLICY HOLDER	POLICY NUMBER	GROUP NUMBER

SIGNATURE

DATE

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital

Medical Questionnaire

Date of visit:________ Age:______ If OB visit, father of baby: ________________

Address:______________________ City:__________ State:_____ Zip:______

Home phone:______________ Work: ______________ Cell:______________

Birth date: ______________ Occupation: ______________________

How did your hear about our office?: ☐ Friend ☐ Ad ☐ Internet search ☐ Other

Name of person who referred you: ______________________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Pharmacy: ______________________

Allergies:______________________ Type of reaction: ______________

Menstrual History: First day of last period:__________ Age of first period: ______________

days of flow:________ Amount (heavy/normal/light):________ Length between periods: ________

Have you ever been pregnant: ☐ No ☐ Yes If yes, how many times: ______________

Full-term:______ # Pre term:______ # Vaginal deliveries:______ #C-section deliveries: ______

Miscarriages:______ # Living children:______ # Abortions:______

Do you use birth control? ☐ No ☐ Yes

If yes, what type: ☐ Pills ☐ Diaphragm ☐ Depo Provera ☐ Norplant ☐ NuvaRing ☐ Abstinence ☐ IUD

☐ Vasectomy ☐ Tubal Ligation ☐ Condoms ☐ Rhythm Method If prescription, name: __________

Medical History: CHECK ALL THAT APPLY:

☐ Cancer? Type:______________

☐ Abnormal PAP Smear? Date:__________

☐ Thyroid issues

☐ Pelvic infection

☐ Sexually transmitted disease

☐ Phlebitis/blood clots in legs

☐ Alcoholism

☐ Mitral valve prolapse

☐ With antibiotic treatment

☐ High cholesterol

☐ High blood pressure

☐ Heart disease

☐ Diabetes

☐ Tuberculosis

☐ Hepatitis

☐ Anemia

☐ Depression

☐ Digestive issues

☐ Drug addiction

☐ Headaches

Surgical History: CHECK ALL THAT APPLY:

☐ Breast

☐ Fibroid Tumors

☐ Hysterectomy

☐ Ovary

☐ D&C

☐ Caesarean Section

☐ Ectopic Pregnancy

☐ Laser/LEEP/Cryo

☐ Other Reasons for Surgery/Findings: ______________________

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital

Please list any other surgery (appendectomy, heart surgery, etc.): ______________________________

____

____

Please list all prescription medication names, dosages and time of day you take them: ______________________________

____

____

Social History/Habits

Do you preform breast exams? ☐ Yes ☐ No How often: ______________________________

Have you had a mammogram of your breast? ☐ Yes ☐ No If so, when:______________ Where:______________

Have you had an abnormal mammogram? ☐ Yes ☐ No If so, when:______________ Where:______________

Do you have an annual Pap Smear? ☐ Yes ☐ No Date of last PAP ______________________________

Have you ever smoked? ☐ Yes ☐ No How much?:____________ ☐ Quit When? ____________

Do you drink alcohol? ☐ Yes ☐ No How much?:______________ How often? ____________

Do you use street drugs? ☐ Yes ☐ No What kind?:______________ How often?____________

Do you exercise? ☐ Yes ☐ No How often? ______________________________

Are you at risk for HIV infection? ☐ Yes ☐ No Age of first intercourse? ______________________

Sexual partners ☐ < than 5 ☐ > than 5

Are you or have you ever been threatened or physically, sexually, or emotionally abused? ☐ Yes ☐ No

Family History

CHECK ALL THAT APPLY TO SIBLINGS, PARENTS AND GRANDPARENTS/HABITS AND LIST THE FAMILY MEMBER

FAMILY MEMBER

☐ Breast cancer: ______________________

☐ Ovarian cancer: ______________________

☐ Other cancer:______________________

☐ Birth defects: ______________________

☐ High blood pressure: ______________________

☐ Heart attack: ______________________

☐ High cholesterol: ______________________

FAMILY MEMBER

☐ Tuberculosis: ______________________

☐ Diabetes: ______________________

☐ Bleeding disorder:______________________

☐ Alcoholism: ______________________

☐ Mental retardation: ______________________

☐ Osteoporosis/osteopenia:______________________

☐ Other: ______________________

Genital/urinary

- ☐ Vaginal warts
- ☐ Vaginal dryness
- ☐ Absence of period
- ☐ Heavy vaginal bleeding
- ☐ Irregular vaginal bleeding
- ☐ Painful menstrual periods
- ☐ Painful intercourse
- ☐ Urinary urgency
- ☐ Pain/burning urination
- ☐ Urination at night
- ☐ Bladder control/Leakage
- ☐ Urinary tract infections

Constitutional

- ☐ Fatigue
- ☐ Hair loss
- ☐ Weight gain or loss
- ☐ Hot flashes

Skin/breast

- ☐ Nipple discharge
- ☐ Sores that don't heal
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Changes in mole
- ☐ Rashes/persistent itching

Neurological

- ☐ Frequent headaches
- ☐ Poor coordination
- ☐ Muscle weakness
- ☐ Trouble sleeping

Psychiatric

- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety
- ☐ Memory changes
- ☐ Counseling or treatment

HENT

- ☐ Vision problems
- ☐ Hearing loss
- ☐ Allergies/Hayfever
- ☐ Hoarseness
- ☐ Frequent sore throat
- ☐ Sinus problems
- ☐ Mouth ulcers
- ☐ Fainting/Dizziness

Digestive

- ☐ Heart burn
- ☐ Mood swings
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Black stools
- ☐ Yellow jaundice

Cardiac

- ☐ Chest pain
- ☐ Irregular heart beat

Respiratory

- ☐ Shortness of breath
- ☐ Coughed blood
- ☐ Wheezing

Emergency contact information

Name of person not living with you | Relationship

Address (street, city, state, zip code) | Home/work phone number

Name of person not living with you | Relationship

Address (street, city, state, zip code) | Home/work phone number

Authorized recipient of information

I hereby authorize Hugh Chatham Women's Center to discuss my (or my dependent child's) medical information, including lab and x-ray results, appointments, referrals, and medication information with:

Name | Relationship

Signature of patient or responsible party | Date

Assignment of benefits

I hereby assign payment directly to Hugh Chatham Women's Center of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

Release of information

I hereby authorize Hugh Chatham Women's Center to release such medical information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Hugh Chatham Women's Center to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them. If I (or my dependent) is referred to another physician whose practice is owned or operated by Hugh Chatham Memorial Hospital, I herby authorize the release of this patient information packet in its entirety.

Privacy notice

I acknowledge that I have received and review the Hugh Chatham Women's Privacy Notice as required by the Health Portability and Accountability Act (HIPPA)

Signature of patient or responsible party | Date

Insurance coverage / spouse or parent

If your insurance coverage is through the employer of your spouse or parent, we must have the policy holder's birth date as well as their social security number in order to file a claim to your insurance company. We apologize for any inconvenience this may cause and appreciate your understanding and compliance with this matter.

Policy Holder's Name: ____

Policy Holder's Social Security Number: ____

Policy Holder's Date of Birth: ____

____
Signature of patient or responsible party   Date

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital

Authorization to Release Information to Family Members

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must complete this form. Signing this form will only give consent to release this information to the family members indicated below. You have a right to revoke this consent in writing.

I authorize/allow Hugh Chatham Women's Center to release my medical and/or billing information to the following:

1. Name: ______________________________

   Relation to patient: ______________________________

2. Name: ______________________________

   Relation to patient: ______________________________

3. Name: ______________________________

   Relation to patient: ______________________________

4. Name: ______________________________

   Relation to patient: ______________________________

______________________________ ______________________________
Patient name Date of Birth

______________________________ ______________________________
Signature of patient Date

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

______________________________ ______________________________
Patient name Date of Birth

______________________________ ______________________________
Signature of patient Date

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital

Pre-Consent Form for Treatment of a Minor/Dependant

This pre-consent form allows parents of minors or legal guardians of dependant adults to grant permission for other responsible adults to bring their child or dependant adult to our office for evaluation or treatment.

The undersigned parent/guardian of: ______________________________

Whose date of birth is: ______________________________

Does hereby empower the following named individuals:

1. Name: ______________________________
   Relation to patient: ______________________________

2. Name: ______________________________
   Relation to patient: ______________________________

3. Name: ______________________________
   Relation to patient: ______________________________

4. Name: ______________________________
   Relation to patient: ______________________________

Express permission to act as my agent to consent to and authorize medical evaluation and treatment for my above/child dependent. This authorization provides authority and power on the part of the above named individuals to give specific consent to any and all such evaluation, diagnosis, office treatment, immunization administration, anesthetic administration, or surgical treatments which a physician, in the exercise of his/her judgement, may deem advisable. This authorization includes hospital admission if such is deemed necessary by the physician.

This authorization shall be valid until or unless revoked by me in writing.

I do hereby indemnify and hold harmless the physicians, staff, an other persons who act in reliance upon this authorization.

______________________________ ______________________________
Parent/guardian name Date of Birth

______________________________ ______________________________
Signature of parent/guardian Date

336-835-5945 • 150 Parkwood Drive • Elkin, NC 28621
HughChathamWomensCenter.com

Hugh Chatham Women's Center
a department of Hugh Chatham Memorial Hospital