Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: ____________________ Date of Birth: ____________ Sex: ________

Address: ____________________ City: ____________ State: ______ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Email: ____________________

Primary Care Physician (if applicable): ____________________

Emergency Contact Name: ____________________ Relationship: ____________ Phone: ____________

INSURANCE INFORMATION

Primary Insurance: ____________________ Employer: ____________________

Insurance ID #: ____________________ Insurance Group #: ____________________

Policy Holder: Name: ____________________ Date of Birth: ____________ Social Security #: ____________

Secondary Insurance: ____________________ Employer: ____________________

Insurance ID #: ____________________ Insurance Group #: ____________________

Policy Holder: Name: ____________________ Date of Birth: ____________ Social Security #: ____________

Responsible Party for Minor: Name: ____________________ Relationship: ____________ Phone: ____________

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Hugh Chatham Medical Group 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 Medical Group to release such medical and billing 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 Medical Group 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 hereby authorize the release of this patient information packet in its entirety.

PRIVACY NOTICE

I acknowledge that I have received the Hugh Chatham Medical Group Privacy Notice as required by the Health Portability and Accountability Act (HIPPA).

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.

AUTHORIZATION TO RELEASE INFORMATION

RELEASE 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 the right to revoke this consent in writing.

I authorize/allow Hugh Chatham Medical Group to release my medical and/or billing information to the following individual(s):

1. ____________________ Relation to patient: ____________
2. ____________________ Relation to patient: ____________

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 or Responsible Person Signature: ____________________ *Date:* ____________ *Time:* ________

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NEW PATIENT REGISTRATION

MEDICAL INFORMATION

Allergies: ______________________________

Reactions: ______________________________

CURRENT MEDICATIONS

Name of Medicine:	Dose (mg):	How Many Times Daily?:

CONDITIONS/HISTORY

Current Medical Conditions:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Surgical History:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

History of Hospitalizations: Date: ______________ Reason: ______________________________

Date: ______________ Reason: ______________________________

Date: ______________ Reason: ______________________________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ______________________________ (Patient Name), do hereby consent and authorize ______________________________ (Practice Name)

to release to Hugh Chatham Medical Group all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and treatment. This may include psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, hepatitis, or drug and/or alcohol abuse.

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice of revocation to Hugh Chatham Medical Group, except to the extent that any action has already been taken on this release. Otherwise consent will remain in force for 90 days. Exclude the following information from the records released (if any): ______________________________

TREATMENT OF A MINOR/DEPENDENT

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

The undersigned parent/guardian of ______________________ Date of Birth ____________does hereby empower and authorize the following named individuals:

1. ______________________ Relation to patient: ______________ 3. ______________________ Relation to patient: ______________

2. ______________________ Relation to patient: ______________ 4. ______________________ 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 best judgment, may deem advisable. This authorization includes hospital admission if such is deemed necessary by the physician.

Patient or Responsible Person Signature: ______________________________ *Date:* ______________ *Time:* ____________

How did you hear about us? ____ **Website** ____ **Facebook** ____ **Friend/Family** ____ **Physician** ____ **Other**

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NEW PATIENT REGISTRATION
HUGH CHATHAM WOMEN'S CENTER

OTHER HISTORY

First Day of Last Menstrual Period: ____________________ Age of First Period: __________

Days of Flow __________ Amount (heavy, normal, light): __________ Length Between Periods: __________

Have you ever been pregnant? Yes _______ No _______ How many times?:__________ # Full Term: _______ # Pre-Term: _______

Vaginal Deliveries: _______ # C-Section Deliveries: _______ # Miscarriages: _______ # Abortions: _______ # Living Children: _______

Dates of Child(ren) Births: ____________________

Do you use birth control? Yes _______ No _______ If yes, what type?:

Pills: _______ IUD: _______ Diaphragm: _______ Vasectomy: _______ Depo Provera: _______ Tubal Ligation: _______ NuvaRing: _______

Nexplanon: _______ Rhythm Method: _______ Condoms: _______ Abstinence: _______

SOCIAL HISTORY/HABITS

Do you perform breast exams? Yes _______ No _______ How often? __________

Have you had a mammogram of your breast? Yes _______ No _______ If yes, when: __________ where: __________

Have you had an abnormal mammogram? Yes _______ No _______ If yes, when: __________ where: __________

Do you a Pap Smear yearly? Yes _______ No _______ Date of last Pap:? __________

Have you ever smoked? Yes _______ No _______ How much? __________ Quit _______ Years: __________

Do you drink alcohol? Yes _______ No _______ How much?: __________ How often?: __________

Do you use illegal drugs? Yes _______ No _______ What kind?: __________ How often?: __________

FAMILY HISTORY

Enter family member for those that apply. (Siblings, Parents, Grandparents)

Breast Cancer __________ Ovarian Cancer __________ Other Cancer __________

Birth Defects __________ High Blood Pressure __________ Heart Attack __________

High Cholesterol __________ Tuberculosis __________ Diabetes __________

Bleeding Disorder __________ Mental Disability __________ Alcoholism __________

Osteoporosis/Osteopenia __________ Other __________

REVIEW OF SYSTEMS

Please check below if you are having problems with any of the following:

GENITAL/URINARY

____ Vaginal Warts ____ Heavy Vaginal Bleeding ____ Painful Intercourse ____ Urination at Night

____ Vaginal Dryness ____ Irregular Vaginal Bleeding ____ Urinary Urgency ____ Bladder Control/Leakage

____ Absence of Period ____ Painful Menstrual Periods ____ Pain/Burning w/ Urination ____ Urinary Tract Infections

CONSTITUTIONAL

____ Fatigue ____ Hair Loss ____ Weight Gain or Loss ____ Hot Flashes

SKIN/BREAST

____ Breast Lumps ____ Nipple Discharge ____ Rashes/Persistent Itching _____ Skin Abnormality

____ Breast Tenderness ____ Sore That Does Not Heal

NEUROLOGICAL

____ Poor Coordination ____ Frequent Headaches ____ Muscle Weakness ____ Trouble Sleeping

PSYCHIATRIC

____ Depression ____ Mood Swings ____ Memory Changes ____ Counseling or Treatment ____ Anxiety

DIGESTIVE

____ Heartburn ____ Rectal Bleeding ____ Diarrhea ____ Yellow Jaundice ____ Vomiting ____ Black Stools

CARDIAC

____ Irregular Heart Beat ____ Chest Pain ____ Other __________

RESPIRATORY

____ Shortness of Breath ____ Coughed Blood ____ Wheezing ____ Asthma