How Did You Hear About Carolina Health Centers?

(Please Check One of the Following)

- ○ Family Member, Friend, or Co-Worker
- ○ Newspaper
- ○ Telephone Book
- ○ Health Fair or Other Community Event
- ○ Radio
- ○ Other: ______________________________

  ____

  ____

Patient Registration Form

Account #:

Patient's Name:______________________ Patient's Gender:
Patient's DOB:__________ Patient's SSN:__________ [ ] Male
Patient's Address:______________________ [ ] Female
Patient's City, State, Zip:______________________
Patient's Home/Cell Phone:__________ Patient's Work/Other Phone:__________

Please select one box from each of the following sections.

Primary Care Provider

[ ] __________

Additional Information

	YES	NO
Veteran		
Homeless		
Migrant Worker		
Seasonal Worker		

Pharmacy

Which Pharmacy do you prefer?

____

Race

- [ ] Black/African American
- [ ] Asian
- [ ] American Indian/Alaskan Native
- [ ] Native Hawaiian/Pacific Islander
- [ ] White

Migrant

Temporarily relocated to another area in order to work primarily in agriculture in the last 12 months

Responsible Party Information

Name:__________
Phone #:__________
Address:__________
City, State, Zip:__________

Ethnicity

- [ ] Hispanic/Latino/or Spanish Origin
- [ ] Non-Hispanic/Latino/or Spanish Origin

Insurance Information

- [ ] Medicaid
- [ ] SC Solutions
- [ ] United Healthcare
- [ ] Blue Choice Health Plan
- [ ] Select Health
- [ ] Blue Cross Blue Shield
- [ ] Cigna
- [ ] Other:__________

Policy 1:__________
Effective Date:__________
Card Holders Sex: **M** **F**
Card Holders Birthdate:__________
Copay Amount $__________
Policy 2:__________
Effective Date:__________
Card Holders Sex: **M** **F**
Card Holders Birthdate:__________
Copay Amount $__________

Employment Status

- [ ] Full Time
- [ ] Part Time
- [ ] Unemployed
- [ ] Student

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed

Emergency Contact Information

Name:__________ Phone #:__________
Address:__________
City, State, Zip:__________
Relationship to Patient:__________

Please keep in mind this person may be contacted if we can not reach you directly for appointment reminders, lab results, or referral appointments.

Sliding Fee Scale Information

We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members.
Please check below:

- [ ] YES, I would like an application for the sliding fee scale.
- [ ] NO, I do not wish to apply for the sliding fee scale at this time.

By Signing below, I agree to be responsible for all the fees that are not paid by insurance. I authorize Carolina Health Centers, Inc. to release ay medical information necessary to process my insurance claims and I authorize assignment of benefits and/or payments directly to Carolina Health Centers, Inc.

______________________ ______________
Signature Date

Acknowledgement of Receipt of Privacy Notice

For office use only:
Patient Name: ____
Medical Record #:______________________ DOB:_____________________
Date of Acknowledgement: ______________________

By signing this form, you acknowledge that Carolina Health Centers, Inc. has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

[ ] I have received Carolina Health Centers, Inc. Privacy Notice.

[ ] Carolina Health Centers, Inc. has given me the chance to discuss my concerns and questions about the privacy of my health information.

[ ] I choose to disclose my information to the following individuals:

_________________________________ _____________________________

_________________________________ _____________________________

____ _______________________________
Patient's Signature **Date**

For office use only

If patient refuses to sign acknowledgement, give patient a copy of the HIPAA form and fill out the following:

1. Did the patient accept a copy of the Privacy Notice? [ ] Yes [ ] No
2. Please explain why the patient was unable to sign an acknowledgement form and Carolina Health Centers, Inc. efforts trying to obtain the patient's signature: ____
____
____
____

ePrescribing Consent

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Carolina Health Centers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. In other words, you are giving us permission to view your prescription medication history so that we may better serve you by sending your prescriptions to the pharmacy electronically. We will be able to view any medications that have been prescribed to you in the past as well as information about whether or not you have gotten a prescription filled.

Understanding all of the above, I hereby provide informed consent to Carolina Health Centers to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name:____ Patient DOB:________________________

Signature of Patient or Guardian:___________________________________ Date: _______________________

Relationship to Patient: ____

HEALTH HISTORY/REVIEW OF SYSTEMS

NAME: ________________________________ AGE:_______ DATE:__________ CHART#:____________

Primary Care Provider: ____

Hospitalizations ____

And Surgeries: ____

____

Medical Problems: ____

____

Medications: ____

____

Allergies: ____

MEDICAL SYMPTOMS: CIRCLE ALL THAT APPLY

General	Use of Tobacco (past or present), Alcohol, Caffeine, or Drugs; Chills; Dizziness; Fainting; Fever; Sweats; History of Cancer; Weight Change; Recurrent Headaches; Anemia; Transfusions; Exposure or Risk of AIDS; Any Exercise? Yes/No Last Tetanus Booster: ____________Last Pneumovax: ______________
Eyes	Crossed Eyes; Double Vision; Pain; Blurred Vision; Glaucoma; Red Eyes
Ears	Earache; Discharge; Loss of Hearing; Ringing in Ears
Nose/Throat	Nosebleeds; Thyroid Problems; Sinus Trouble; Hay Fever; Hoarseness; Teeth or Gum Problems
Cardiovascular	Chest Pain; High Blood Pressure; Irregular Heart Beat; Poor Circulation; Murmur; Heart Attacks; Heart Disease; Shortness of Breath; High Cholesterol
Respiratory	Chronic Cough; Asthma; Emphysema; Coughing up Blood; Pneumonia; Wheezing; Night Sweats
Gastrointestinal	Poor Appetite; Bowel Changes; Constipation; Diarrhea; Nausea; Ulcers; Rectal Bleeding; Liver Disease; Jaundice; Hepatitis; Gallbladder Disease; Hemorrhoids; Blood in Stools; Dark or Black Stools
Genitourinary	Blood in Urine; Painful Urination; Difficult Urination; Prostate Problems; Kidney Stones; Venereal Disease; Sexual Difficulties
Musculoskeletal	Arthritis; Gout; Fractures; Chronic Back Pain; Injuries
Neurologic	Confusion; Head Injury; Numbness; Seizures; Fainting; Stroke; Dizziness
Psychiatric	Anxiety; Depression; Drug Addiction; Suicide Attempt; Sleeping Difficulties; Marital Problems
Endocrine	Diabetes; Lethargy or Fatigue; Heat or Cold Intolerance; Thyroid Disease
Skin Diseases	Dry Skin; Skin Cancers; Sores that Don't Heal; Changing Moles
Gynecological (females only)	Last Pap Smear:_______Last Mammogram;_______# of Pregnancies:________# of Births:________ Birth Control Method: None – Pill – Condoms – Diaphragm – Rhythm – IUD – Shots – Tubal – Vasectomy-Other Irregular of Painful Periods; Bleeding Between Periods or after Sex
Family History	Circle Illnesses that Parents or Siblings Have or Have Had: Diabetes; Heart Disease; Hypertension or High Blood Pressure; Cancer; Alcohol Abuse; Strokes; Asthma; Depression; Tuberculosis, Glaucoma

Other Comments

________________________________ ________________________

Provider Signature DATE