❑ FHC at Biltmore ❑ FHC at Cane Creek ❑ FHC at Newbridge ❑ FHC at Enka/Candler

❑ Center for Psychiatry ❑ Deerfield ❑ Givens

MAHEC

FAMILY HEALTH CENTERS PATIENT REGISTRATION FORM

Please complete the following information using BLACK ink. ****This information is confidential****

Name _____ SS #_____

Address _____ City_____State_____ Zip_____

Home county _____E-mail address _____

Home phone _____ Work/cell phone _____

By providing a phone number, mobile phone number or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Birth Date _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ In a relationship ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

In case of emergency, contact:

Name_____ Relationship _____ Phone #_____

IF PATIENT IS CHILD (18 & UNDER): Responsible Party Name:_____

Relationship to patient _____ Phone #_____

Please list: Special hearing needs: _____ Special vision needs: _____

What is your race / ethnicity? (check all that apply):

❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander

❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Other (please describe):_____

Preferred Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Other_____

INSURANCE INFORMATION

Insurance company _____

Policy holder's name _____ Policy holder's date of birth _____

Policy holder's relationship to patient: _____

Policy holder's address: _____

_____

Policy holder is ❑ male ❑ female Policy ID# _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to MAHEC Family Health Center and I authorize them to file insurance on my behalf. I also authorize them to release medical/and or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand MAHEC Family Health Center:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice

.

I have read and understand the above: _____ Date_____

Patient or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient, Parent or Guardian Signature _____ Date_____

VERBAL COMMUNICATION CONSENT

MAHEC is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

_____ _____

_____ _____

Today's Date: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature _____ Date_____

FOR OFFICE USE ONLY: Primary Care Provider _____

Copy of insurance card obtained? ❑ yes ❑ no

MAHEC

New Pediatric Patient Intake Form (Birth–17)

☐ BILTMORE ☐ CANE CREEK ☐ ENKA ☐ NEWBRIDGE ☐ SWANNANOA

Patient Name: _____ Date of Birth: _____

Form Completed by: _____ Date of Today's Visit: _____

Has the patient received medical care from another physician in the last 5 years? ☐ Yes ☐ No If yes, please list them below.

Physician name: **Physician city and state:**

_____ _____

_____ _____

_____ _____

What is the reason for the patient's visit today? _____

ALLERGIES

Does the patient have any allergies or bad reactions to medicines, foods or latex? ☐ Yes ☐ No If yes, please list them below.

Medicine, food, latex or other substance: **Reaction caused:**

_____ _____

_____ _____

MEDICATIONS

Please list ALL medications the patient currently takes (including birth control pills, vitamins, supplements and herbs) even if they are not taken every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement:	Dosage (ex: how many mg or tablets taken)	How often it is taken:

Is the patient taking a multivitamin? ☐ Yes ☐ No

Local Pharmacy: _____ Mail Order: _____

MEDICAL HISTORY

Has the patient ever had any of the following? Please check the boxes of all that apply.

☐ Anemia
☐ Anxiety
☐ Asthma
☐ Attention Deficit Disorder
☐ Behavior problems
☐ Bladder problems
☐ Cancer, specify: _____
☐ Depression
☐ Developmental delays
☐ Diabetes
☐ GERD/Reflux
☐ Heart disease, congenital (at birth)
☐ Hepatitis, choose: ☐ A ☐ B ☐ C
☐ History of physical abuse
☐ History of sexual abuse
☐ Kidney disease, congenital (at birth)
☐ Migraines
☐ Seizures
☐ Sexually Transmitted Infection
☐ Thyroid trouble, congenital (at birth)

Other medical history: _____

_____

Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY

What surgeries or procedures has the patient had? Please check the boxes of all that apply.

☐ No surgeries ☐ Heart surgery Other surgeries: _____

☐ Appendix removed ☐ Hernia repair ☐ Left ☐ Right _____

☐ Circumcision ☐ Knee surgery ☐ Left ☐ Right _____

☐ Ear tubes ☐ Tonsils removed _____

REPRODUCTIVE HISTORY

If the patient has had their first period, how old? _____ If the patient has ever been pregnant, how many pregnancies? _____

Number of live births: _____ Number of living children: _____ Number of C-Sections: _____

Number of miscarriages: _____ Number of still births: _____ Number of abortions: _____

BIRTH HISTORY

The patient was born via: ☐ Vaginal delivery ☐ C-Section The patient was born: ☐ Early ☐ On-Time ☐ Late

Any problems during the mother's pregnancy or during delivery? _____

Did the patient have any problems after birth? _____ Birth Weight: _____

IMMUNIZATION HISTORY

Are the patient's childhood vaccinations up to date? ☐ Yes ☐ No

Has the patient had a flu vaccine within the last year? ☐ Yes ☐ No

Have vaccinations for the patient ever been declined or delayed? ☐ Yes ☐ No If yes, please list them below.

_____

FAMILY MEDICAL HISTORY

Family medical history unknown? ☐ Yes ☐ No

Please indicate if the patient's biologic mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

☐ ADHD	Who? _____	☐ High blood pressure	Who? _____
☐ Alcohol abuse	Who? _____	☐ High cholesterol	Who? _____
☐ Anemia	Who? _____	☐ Kidney disease	Who? _____
☐ Anesthesia complications	Who? _____	☐ Lung problems	Who? _____
☐ Anxiety	Who? _____	☐ Melanoma	Who? _____
☐ Asthma	Who? _____	☐ Migraines	Who? _____
☐ Blood clots	Who? _____	☐ Osteoporosis	Who? _____
☐ Cancer, specify: _____	Who? _____	☐ Other mental illness	Who? _____
☐ Depression	Who? _____	☐ Seizures	Who? _____
☐ Diabetes, how old: _____	Who? _____	☐ Stroke, how old: _____	Who? _____
☐ Eczema	Who? _____	☐ Thyroid trouble	Who? _____
☐ Heart attack, how old: _____	Who? _____		

Other family medical history: _____

_____

If the patient's biologic father is deceased, how old was he when he died? _____ What did he die from? _____

If the patient's biologic mother is deceased, how old was she when she died? _____ What did she die from? _____

Patient Name: _____ Date of Birth: _____

EDUCATION HISTORY

Current School: _____

Current Grade: _____ School Performance: _____

Has the patient missed more than 10 days in the past year? ☐ Yes ☐ No

HEALTHY HABITS

Is the patient exposed to sun without protection?

☐ Sometimes ☐ Rarely ☐ Never

Does the patient always wear a seat belt or use a car seat (if applicable) when in a moving vehicle?

☐ Yes ☐ No

How often does the patient participate in physical activity?

☐ None
☐ 1-2 times per week
☐ 3-5 times per week
☐ 6-7 times per week

How long is the patient physically active?

☐ Less than 15 minutes
☐ 15-30 minutes
☐ 30-45 minutes
☐ 60+ minutes

What type of physical activity does the patient participate in?

_____

Does the patient wear a helmet when appropriate?

☐ Yes ☐ No

How much screen time does the patient participate in daily?

_____

Are there guns in the patient's home? ☐ Yes ☐ No

If yes, are they stored locked and unloaded? ☐ Yes ☐ No

Problems with bullying? ☐ Yes ☐ No

Are there smokers in the patient's household? ☐ Yes ☐ No

HOUSEHOLD

The following people make up the patient's household.

Name: _____

Year born: _____ Relation to child: _____

Name: _____

Year born: _____ Relation to child: _____

Name: _____

Year born: _____ Relation to child: _____

Name: _____

Year born: _____ Relation to child: _____

ADOLESCENTS ONLY (rest of this page)

Does the patient ever use their phone to text while driving?

☐ Yes ☐ No

SEXUAL HISTORY

Is the patient sexually active? ☐ Yes ☐ No

What is the gender of their sexual partner(s)? _____

What is the patient's gender identity? _____

What is the patient's sexual orientation? _____

TOBACCO USE

☐ The patient has never used tobacco
☐ The patient has smoked, started at age: _____
☐ The patient still smokes _____ packs per day
☐ The patient quit _____ (date) but used to smoke _____ packs per day
☐ The patient has tried to quit _____ times
☐ The patient chews or uses smokeless tobacco
☐ The patient vapes or uses e-cigarettes

REPRODUCTIVE LIFE PLANNING

Would the patient like to become pregnant in the next year?

☐ Yes
☐ No
☐ Okay either way
☐ Unsure

Is the patient using any method to prevent pregnancy?

☐ Yes ☐ No

If yes, what: _____

Does the patient use condoms? ☐ Yes ☐ No

DEPRESSION SCREENING (PHQ-2)

Over the past two weeks, how often has the patient been bothered by the following problems?

Little interest or pleasure in doing things:

☐ Not at all (0)
☐ Several days (1)
☐ More than half of the days (2)
☐ Nearly every day (3)

Feeling down, depressed or hopeless:

☐ Not at all (0)
☐ Several days (1)
☐ More than half of the days (2)
☐ Nearly every day (3)

Patient Name: _____ Date of Birth: _____

PEDIATRIC REVIEW OF SYSTEMS

Please check the boxes of any symptoms the patient has had in the past 2 weeks.

GENERAL
- ❑ Fevers
- ❑ Weight loss

SKIN
- ❑ Rash

EYES/EARS/NOSE/THROAT/MOUTH
- ❑ Crossed eyes
- ❑ Hearing trouble
- ❑ Teeth/gum problems
- ❑ Runny nose
- ❑ Seasonal allergies
- ❑ Snoring
- ❑ Squinting

LUNGS
- ❑ Cough
- ❑ Breathing problems
- ❑ Wheeze

HEART
- ❑ Chest pain
- ❑ Tires easily with exertion

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Blood in bowel movement
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

GENITOURINARY
- ❑ Bed wetting
- ❑ Decreased urination
- ❑ Pain with urination

MUSCLES/SKELETON
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle pain

NEUROLOGICAL
- ❑ Fainting
- ❑ Headaches

MENTAL HEALTH
- ❑ Anxiety
- ❑ Behavior problems
- ❑ Breath holding
- ❑ Depression
- ❑ Sleep problems
- ❑ Speech problems

BLOOD/LYMPH
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Unexplained lumps

OTHER
_____

_____

_____

_____

_____

MAHEC

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist Ages 4-10

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

MAHEC

Pediatric Symptom Checklist - Youth Report (Y-PSC) Ages 11-16

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains.....	___	___	___
2. Spend more time alone.....	__	___	___
3. Tire easily, little energy.....	___	___	___
4. Fidgety, unable to sit still.....	___	___	___
5. Have trouble with teacher……	___	___	___
6. Less interested in school.……...	___	___	___
7. Act as if driven by motor.....	___	___	___
8. Daydream too much.....	___	___	___
9. Distract easily.....	___	___	___
10. Are afraid of new situations.....	___	___	___
11. Feel sad, unhappy.....	___	___	___
12. Are irritable, angry.....	___	___	___
13. Feel hopeless.....	___	___	___
14. Have trouble concentrating.....	___	___	___
15. Less interested in friends.....	___	___	___
16. Fight with other children.....	___	___	___
17. Absent from school. …….	___	___	___
18. School grades dropping. ……..	___	___	___
19. Down on yourself.....	___	___	___
20. Visit doctor with doctor finding nothing wrong.....	___	___	___
21. Have trouble sleeping.....	___	___	___
22. Worry a lot.....	___	___	___
23. Want to be with parent more than before.....	___	___	___
24. Feel that you are bad.....	___	___	___
25. Take unnecessary risks.....	___	___	___
26. Get hurt frequently.....	___	___	___
27. Seem to be having less fun.....	___	___	___
28. Act younger than children your age.....	___	___	___
29. Do not listen to rules.....	___	___	___
30. Do not show feelings.....	___	___	___
31. Do not understand other people's feelings.....	___	___	___
32. Tease others.....	___	___	___
33. Blame others for your troubles.....	___	___	___
34. Take things that do not belong to you.....	___	___	___
35. Refuse to share.....	___	___	___

INCOMING TO MAHEC

MAHEC Family Health Center
Centralized Medical Records Department
123 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 | Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: _____ **Date of Birth:**_____

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	**MAHEC Family Health Center** **Centralized Medical Records Dept.**
ADDRESS:	**123 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

- ❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- ❑ Only information related to *(specify)*: _____
- ❑ Only the period of events from: _____ to _____
- ❑ Entire medical record
- ❑ Exclusions
  - __ AIDS/HIV test results, diagnosis, treatment, and related information
  - __ Drug screen results and information about drug and alcohol use and treatments
  - __ Mental health notes
  - __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. _____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.