❑ 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 Patient Intake Form - Women Ages 18-64

☐ BILTMORE ☐ CANE CREEK ☐ ENKA ☐ LAKE LURE ☐ NEWBRIDGE ☐ SWANNANOA

Patient Name: _____ Date of Birth: _____

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

Have you received medical care from another physician in the last 5 years? ☐ Yes ☐ No If yes, please give name and location.

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

_____ _____

_____ _____

_____ _____

What is the reason for your visit today? _____

ALLERGIES

Do you 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 you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

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

Local Pharmacy: _____ Mail Order: _____

MEDICAL HISTORY

Have you ever had any the following? Please check the boxes of all that apply to you.

☐ Alcohol abuse
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Attention Deficit Disorder
☐ Bipolar Disorder
☐ Bladder problems
☐ Blood clots
☐ Breast cancer, when: _____
☐ Colorectal cancer, when: _____
☐ Cancer, other: _____
☐ COPD/Emphysema
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ GERD/Reflux
☐ Heart attack, when: _____
☐ Heart failure
☐ Hepatitis, choose: ☐ A ☐ B ☐ C
☐ High blood pressure
☐ High cholesterol
☐ History of physical abuse
☐ History of sexual abuse
☐ Irritable Bowel Syndrome
☐ Kidney disease
☐ Kidney stones
☐ Migraines
☐ Osteoporosis
☐ Seizures
☐ Sexually Transmitted Disease
☐ Skin cancer, when: _____
☐ Stroke
☐ Thyroid trouble
☐ Other:
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- ☐ Amputation, where: _____ Year: _____
- ☐ Appendix removed Year: _____
- ☐ Artificial joints, where: _____ Year: _____
- ☐ Back surgery Year: _____
- ☐ Breast surgery ☐ Left ☐ Right Year: _____
- ☐ Cataract extraction ☐ Left ☐ Right Year: _____
- ☐ Catheterization of heart Year: _____
- ☐ Gall bladder removed Year: _____
- ☐ Heart surgery Year: _____
- ☐ Hernia repair ☐ Left ☐ Right Year: _____
- ☐ Knee surgery ☐ Left ☐ Right Year: _____
- ☐ Neck surgery Year: _____
- ☐ Ovaries removed ☐ Left ☐ Right Year: _____
- ☐ Stress test of heart Year: _____
- ☐ Tonsils removed Year: _____
- ☐ Tubes tied Year: _____
- ☐ Uterus removed Year: _____
- ☐ Vasectomy Year: _____

Description of surgery or any other surgeries you have had: _____

_____

REPRODUCTIVE HISTORY

How many pregnancies have you had? _____ Number of live births: _____ Number of living children: _____

Number of C-Sections: _____ Number of miscarriages: _____ Number of still births: _____ Number of abortions: _____

Menopause ('change of life') since: _____

IMMUNIZATION HISTORY

Are your childhood vaccinations up to date? ☐ Yes ☐ No ☐ Unsure Have you had the following vaccines?

- Flu (this year) ☐ Yes ☐ No Date: _____
- Hepatitis B ☐ Yes ☐ No Date: _____
- Pneumonia (Prevnar) ☐ Yes ☐ No Date: _____
- Pneumonia (Pneumovax) ☐ Yes ☐ No Date: _____
- Pertussis ("whooping cough") ☐ Yes ☐ No Date: _____
- Shingles ☐ Yes ☐ No Date: _____
- Tetanus ☐ Yes ☐ No Date: _____
- Others: _____ ☐ Yes ☐ No Date: _____

FAMILY MEDICAL HISTORY

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

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

If your father is deceased, how old was he when he died? _____ What did he die from? _____

If your mother is deceased, how old was she when he died? _____ What did she die from? _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Please indicate your marital or relationship status.

☐ Single ☐ Married since: _____

☐ Not married, living together since: _____

☐ Separated since: _____

☐ Divorced since: _____

☐ Widowed since: _____

SEXUAL HISTORY

Age you became sexually active: _____

Number of sexual partners in the last year: _____

What is your gender identity? _____

What is your sexual orientation? _____

ALCOHOL USE

On average, how many alcoholic beverages do you drink per week? _____

OCCUPATION

☐ Currently employed at: _____

Doing: _____

_____ Since: _____

☐ Homemaker since: _____

☐ Retired since: _____

☐ Former job: _____

☐ Disabled due to: _____ Since: _____

HEALTHY HABITS

Are you exposed to sun without protection?

☐ Sometimes ☐ Rarely ☐ Never

Do you always wear a seat belt? ☐ Yes ☐ No

Do you ever use your phone to text while driving (including while stopped)? ☐ Yes ☐ No

Do you drink caffeine daily? ☐ Yes ☐ No

If yes, how many servings of the following per day?

___ sodas ___ cups of coffee ___ energy drinks ___ tea

HOUSEHOLD

Are any of the following problems present in your household?

☐ Alcohol or other substance abuse

☐ Financial problems

☐ Difficulties being a caregiver

☐ Marital or relationship problems

☐ Recent significant loss of a family member

☐ Transportation issues

☐ Other household problems, explain: _____

_____

The following people make up my household.

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Name: _____

Year born: _____ Relation to me: _____

Patient Name: _____ Date of Birth: _____

REPRODUCTIVE LIFE PLANNING

Are you using any method to prevent pregnancy?

☐ Yes ☐ No

If yes, what: _____

COLORECTAL HEALTH

Date of most recent colonoscopy: _____

Was it normal? ☐ Yes ☐ No

Date of other colorectal cancer screening: _____

Was it normal? ☐ Yes ☐ No

WOMEN'S HEALTH

Have you ever had an abnormal pap test?

☐ Yes ☐ No

When was your last pap? _____

Was it normal? ☐ Yes ☐ No

When was your last mammogram? _____

Was it normal? ☐ Yes ☐ No

When was your last bone density (DEXA) scan? _____

Was it normal? ☐ Yes ☐ No

ADVANCED CARE PLANNING

Have you filled out forms to indicate your desires for end of life care? Living Will: ☐ Yes ☐ No

Durable power of attorney for healthcare ("DPOA"): ☐ Yes ☐ No If yes, who: _____

COMPREHENSIVE REVIEW OF SYSTEMS

Please check the boxes of any symptoms you have had in the past 2 weeks.

General
- ☐ Fatigue
- ☐ Fevers
- ☐ Loss of appetite
- ☐ Unplanned weight gain
- ☐ Unplanned weight loss

Skin
- ☐ New sore or lesion
- ☐ Non-healing sores
- ☐ Rashes

Eyes/Ears/Nose/Throat/Mouth
- ☐ Began wearing glasses or contacts
- ☐ Change in vision
- ☐ Bad teeth
- ☐ Dentures
- ☐ Frequent stuffy nose
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Seasonal allergies
- ☐ Sinus pain
- ☐ Snoring

Lungs
- ☐ Breathing problems
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing

Breasts
- ☐ Breast lump
- ☐ Breast pain

Cardiovascular
- ☐ Chest pain or pressure
- ☐ Heart beats fast
- ☐ Heart skips
- ☐ Short of breath with exercise
- ☐ Short of breath lying down
- ☐ Waking at night short of breath
- ☐ Swelling or edema

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black tarry stool
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea

Gastrointestinal, continued
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Women's Health
- ☐ Bleeding after menopause
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Pain or burning with urination
- ☐ Problems with sex
- ☐ Trouble with periods

Muscles and Skeleton
- ☐ Backache
- ☐ Muscle pain
- ☐ Painful joints

Neurological
- ☐ Fainting or passing out
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Sense of room spinning
- ☐ Tremor
- ☐ Unsteadiness or imbalance
- ☐ Weakness

Mental Health
- ☐ Change in sleep pattern
- ☐ Feeling nervous, anxious or on edge

Endocrine
- ☐ Excessive thirst
- ☐ Hot flashes

Blood
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen glands

Other: _____

_____

_____

_____

MAHEC

Patient Name: _____

Date of Birth: _____

Appt. Type: _____

Provider: _____

IMPORTANT INFORMATION ABOUT TODAY'S VISIT

Complete Physical Exam / Annual Preventative Exam / Annual Wellness Visit

Your insurance will cover one visit per year to discuss preventative care with your provider. These wellness visits are important so we can assess risk factors for diseases and discuss what test may be needed to screen for illness. Our goal is to keep you well!

A wellness visit does not address new or existing health problems, medication adjustments, referrals etc. If at the time of your wellness visit there are separate issues which need to be addressed then we are required by your insurer to bill you for that service. You will likely owe a copay in that situation.

As time allows, your provider will address these issues during your wellness visit. In some cases, we may need to schedule a separate appointment on a different day to treat these problems.

Patient name: _____ Patient Signature: _____

Date: _____

Thank you for taking the time to invest in your health by coming in for your wellness visit today.

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.