

360 Plain View Hwy Dunn, NC 910.236.0182 www.SampsonRMC.org/SMG

# **Patient Registration**

Patient Name:First				DOB:
First	Middle		Last	
Address: Street Address	City	State	Zip Code	Email Address
		State	Zip code	Elimii i idaless
Phone: Home	l	Work		Cell
Employer:				
Race:CaucasianA	African American	Hispa	anic	Native American
Social Security Number:			-	
Marital Status:	Spou	se's Name	:	
Emergency Contact: Relationship:				
Emergency Contact Phone Number	:			
Insurance Company:				
Subscriber Name:	Su	bscriber So	ocial Securit	y Number:
Subscriber Employer:	oscriber Employer: Subscriber Birthdate:			
Preferred Pharmacy:			· · · · · · · · · · · · · · · · · · ·	
	9.50			
Financial Agreement & Authorizati	on of Treatment			
understand that additional charges c	ould apply as well a surance company pa	s charges ay directly	from other	at the time services are rendered. I medical facilities if additional test- on Medical Group and authorize the
D. C. (D. (C. 1) /D. CAV	<u> </u>	D 1 4		<del>-</del> <del>-</del> -
Patient (Parent/Guardian/Power of Atto	orney) Signature	Relations	шр	Date
W				
Witness *As a witness, I am	witnessing the signat	ure and no	ot the conten	Date ts of this document.



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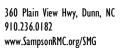
## **Health History**

Date:	<del></del>				
Name:		Date of Birth:	Date of Birth:		
	ies:				
Right Now what are yo	our <u>Current Symptoms</u> , check if an	ny:			
Fever/Chills	Painful or Bloody Urination	Memory Loss	Difficulty Sleeping		
Unexplained Weight Loss	Leaking Urine	Fainting/Dizziness	Anxiety		
Excessive Tiredness	Difficulty Urinating	Numbness	Heartburn		
Blurry Vision	Cough	Difficulty Walking	Nausea/Vomiting		
Eye Pain	Wheezing	Muscle Weakness	Diarrhea/Constipation		
Itchy, Watery Eyes	Shortness of Breath	Joint Pain	Abdominal Pain		
Ear Pain	Chest Pain or Discomfort	Rash	Breast Mass		
Hearing Loss	Palpitations	Itching	Nipple Discharge		
Trouble Swallowing	Leg Pain	Non-Healing Ulcers	Breast Pain		
Allergies or Nasal Congestion	Headaches	Excessive Sadness			
Please check if you eve	r have been diagnosed with any of	the following medical proble	ms:		
Asthma	Depression	Hepatitis	Irregular Heart Rate		
Cancer	Diabetes	High Blood Pressure	Kidney Disease		
COPD	Heart Disease	High Cholesterol	Thyroid Problems		
•	es controlled by Insulin Pills surgeries & approximate dates.				
Surgery:		Date:			
Surgery:		Date:			

Approved Date: 6/1/2015 Form# SMG-0006E

Social History				
Tobacco Use: Never	Current Smoker Prev	ious Smoker	Uses Oral Tobacco	
Alcohol Use: None	Occasional Daily Us	se		
Family History				
Please indicate any immedia	te family members (Mother, Fat	her, Sibling or (	Child) that have had any	of the following
Who	r	Who		Who
Heart Disease	Diabetes		Breast Cancer	
Thyroid Disease	Kidney Disease		Colon Cancer	
High Blood Pressure	Bleeding Disorder		Prostate Cancer	
•	our most preventive health immu			
Flu Shot			imonia vaccine	
Bone Density	Eye Exam			
Men: Prostate Exam				
Women: Mammogram	Pap Smear	•		
Women's Health				
Number of pregnancies	Number of live b	oirths		
First day of last menstrual po	eriodNumbe	er of periods per	year	
Are you experiencing any pr	oblems with your periods?			
Medication List				
Please list all current medica	tions.			

Approved Date: 6/2015, 3/2017 Form# SMG-0006E





### **Authorization for Release of Medical Records**

	Phone Number
Address	Fax Number
Patient Name:	Date of Birth:
Covering Health Care from: to to	Date
Information to be disclosed:  Complete Medical Record  (Please provide the last 2 years of office immunizations, patient health summary.	
Other:	
Fax all records	to (910) 590-8752.
I hereby authorize the release of my health info understand that this may include information re HIV (Human Immunodeficiency Virus), behave treatment of alcohol and/or drug abuse. I am tr	lating to AIDS (Acquired Immunodeficiency), or oral health services or psychiatric care, and/or
I understand this authorization may be revoked action has been taken in reliance on this authorization will expire in (90) days or on the	

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Revised Date: 5/21/2019



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### **Medical Record/Information Release**

t me regarding my he following ways:	nealthcare needs
cell phone.	s $\square$ No
□Ye	s
☐ Ye	s No
s my healthcare needs ple listed below. I ur	s (may include nderstand that I can add
_ Relationship:	
_	
Relationship:	
_	
olina Health Informan, or PHI, with the Nahealth care to you. It paid for with funds hare other patient da Connex to share your just opt out by submit a reavailable in officer at Sampson Regit out of NC Health Coprograms. Your pat	Exchange Network, called ation Exchange Authority IC HIEA and may use NOWe are required by law to from North Carolina prota with NC HealthConnet PHI with other health caroling a form directly to the our offices and online a gional Medical Center, 60' connex, we still will submittent data may also be exmitted or required by law atients.
Relationship	Date
	re following ways:  cell phone. Ye  Ye  Ye  s my healthcare needs ple listed below. I un  Relationship:  Relationship:  Relationship:  Health Information polina Health Information, or PHI, with the Nice health care to you. It is paid for with funds hare other patient da Connex to share your pust opt out by submit ex are available in efficer at Sampson Regit out of NC Health Coprograms. Your patarch purposes as per

Approved Date: 6/1/2015

Revised Date: 04/2021

Form# SMG-0005E



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## **Privacy Practice Acknowledgement**

IPrivacy Practices from Sam	pson Medical Group.	have received a co	ppy of the Notice of
Patient (Parent/Guardian/Powe	er of Attorney) Signature	Relationship	Date
Witness *As a witness, I an	witnessing the signature	- and not the contents	Date of this document.
	FOR OFFICE U	ISE ONLY	
We were unable to obtain a war Practices because:	<u> </u>	•	e of Privacy
•	nd a signature was not pos	ssible at the time.	
The patient refused to si	gn.		
A copy was mailed with	a request for a signature	y return mail.	
Unable to communicate	with the patient for the fo	llowing reason:	
Other:			
SMG Staff	Signature		Date

Approved Date: 6/1/2015 Form# SMG-0004E