



603 Beaman Street, Suite 402, Clinton NC
910.590.3397
www.SampsonRMC.org/SFM

Patient Registration

Patient Name: _____ DOB: _____
First Middle Last

Address: _____
Street Address City State Zip Code Email Address

Phone: _____
Home Work Cell

Employer: _____

Race: _____ Caucasian _____ African American _____ Hispanic _____ Native American

Social Security Number: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Insurance Company: _____

Subscriber Name: _____ Subscriber Social Security Number: _____

Subscriber Employer: _____ Subscriber Birthdate: _____

Preferred Pharmacy: _____

Financial Agreement & Authorization of Treatment

I authorize treatment and agree to pay all fees and charges for such treatment at the time services are rendered. I understand that additional charges could apply as well as charges from other medical facilities if additional testing is required. I request that my insurance company pay directly to Sampson Family Medicine and authorize the release of medical information to my insurance company.

Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

Witness Date

**As a witness, I am witnessing the signature and not the contents of this document.*



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Health History

Date: _____

Name: _____ Date of Birth: _____

Known Medical Allergies: _____

Right Now what are your **Current Symptoms**, check if any:

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 ever have been diagnosed with any of the following medical problems:

Asthma		Depression		Hepatitis		Irregular Heart Rate	
Cancer		Diabetes		High Blood Pressure		Kidney Disease	
COPD		Heart Disease		High Cholesterol		Thyroid Problems	

If diabetic, is your diabetes controlled by ☐ Insulin ☐ Pills

Please list any **current** surgeries & approximate dates.

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Social HistoryTobacco Use: ☐ Never ☐ Current Smoker ☐ Previous Smoker ☐ Uses Oral TobaccoAlcohol Use: ☐ None ☐ Occasional ☐ Daily Use**Family History**

Please indicate any immediate family members (Mother, Father, Sibling or Child) that have had any of the following:

	Who		Who		Who
Heart Disease			Diabetes		Breast Cancer
Thyroid Disease			Kidney Disease		Colon Cancer
High Blood Pressure			Bleeding Disorder		Prostate Cancer

Preventive Health

Please indicate the date of your most preventive health immunizations:

Flu Shot _____ Tetanus _____ Pneumonia Vaccine _____

Bone Density _____ Eye Exam _____

Men: Prostate Exam _____

Women: Mammogram _____ Pap Smear _____

Women's Health

Number of pregnancies _____ Number of live births _____

First day of last menstrual period _____ Number of periods per year _____

Are you experiencing any problems with your periods? _____

Medication List

Please list all current medications.



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Authorization for Release of Medical Records

Medical records requested from:

Name of Facility or Provider

Phone Number

Address

Fax Number

Patient Name: _____ Date of Birth: _____

Covering Health Care from: _____ to _____
Date Date

Information to be disclosed:

Complete Medical Record

☐

(Please provide the last 2 years of office notes, consults, diagnostic studies, immunizations, patient health summary, etc.)

Other: _____

☐

Fax all records to (910) 592-1334.

I hereby authorize the release of my health information to Sampson Family Medicine. I understand that this may include information relating to AIDS (Acquired Immunodeficiency), or HIV (Human Immunodeficiency Virus), behavioral health services or psychiatric care, and/or treatment of alcohol and/or drug abuse. I am transferring care to Sampson Family Medicine.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in (90) days or on the following date/condition: _____

Patient (Parent/Guardian/Power of Attorney) Signature

Relationship

Date

Witness

Date

**As a witness, I am witnessing the signature and not the contents of this document.*



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Medical Record/Information Release

I give permission to Sampson Family Medicine to contact me regarding my healthcare needs (may include diagnoses, test results, appointments) in the following ways:

Leave a message on my answering machine at home or cell phone. ☐ Yes ☐ No

Leave a message at my work for me to return your call. ☐ Yes ☐ No

Mail lab/x-ray results to my home address. ☐ Yes ☐ No

I also agree to allow Sampson Family Medicine staff to discuss my healthcare needs (may include diagnoses, test results, appointments) with the following people listed below. I understand that I can add or remove people included on this list as needed:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Disclosure to Health Information Exchanges

Sampson Family Medicine participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NCHIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our offices and online at NCHealthConnex.gov. You may also contact our Privacy Officer at Sampson Regional Medical Center, 607 Beaman Street, Clinton, NC 28328. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your health care services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients.

Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

Witness Date

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Privacy Practice Acknowledgement

I _____, have received a copy of the Notice of Privacy Practices from Sampson Family Medicine.

Patient (Parent/Guardian/Power of Attorney) Signature

Relationship

Date

Witness

Date

**As a witness, I am witnessing the signature and not the contents of this document.*

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The patient refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____

- ☐ Other: _____

SMG Staff

Signature

Date