SAMPSON MEDICAL GROUP
304 Hwy 24 West Roseboro, NC
910.525.5848
www.SampsonRMC.org/SMG

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 Medical Group 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.*

Approved Date: 6/1/2015
Revised Date: 8/21/2018, 4/2019
Form# SMG-0003E

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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 History

Tobacco Use: ☐ Never ☐ Current Smoker ☐ Previous Smoker ☐ Uses Oral Tobacco

Alcohol 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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Medical Record/Information Release

I give permission to Sampson Medical Group 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 Medical Group 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 Medical Group 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

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

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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) 525-3838.**

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

I understand this authorization may be revoked in writing at any time, excepet 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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Privacy Practice Acknowledgement

I _____, have received a copy of the Notice of Privacy Practices from Sampson Medical Group.

_____ _____ _____
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