Hugh Chatham Medical Group
an affiliate of Hugh Chatham Memorial Hospital

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Social Security #: _____Primary Care Physician (if applicable): _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Employer: _____

Insurance ID #: _____ Insurance Group #: _____

Policy Holder: Name: _____ Date of Birth: _____ Social Security #: _____

Secondary Insurance: _____ Employer: _____

Insurance ID #: _____ Insurance Group #: _____

Policy Holder: Name: _____ Date of Birth: _____ Social Security #: _____

Responsible Party for Minor: Name: _____ Relationship: _____Phone: _____

INFECTIOUS DISEASE SCREENING

Have you recently lived in or traveled to a country with widespread disease transmission OR been in contact with an individual with a confirmed infectious disease within the previous 21 days? _____ Yes _____ No (if yes, fill out Infectious Disease Medical Screening)

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Hugh Chatham Medical Group of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered.

RELEASE OF INFORMATION

I hereby authorize Hugh Chatham Medical Group to release such medical and billing information as may be required by any insurance company concerned with payment of benefits for me (or my dependent child). I further authorize Hugh Chatham Medical Group to release medical information to any facility or physician to whom I (or my dependent child) am/are referred. These authorizations shall remain in effect until I provide written notice revoking them. If I (or my dependent) is referred to another physician whose practice is owned or operated by Hugh Chatham Memorial Hospital, I hereby authorize the release of this patient information packet in its entirety.

PRIVACY NOTICE

I acknowledge that I have received the Hugh Chatham Medical Group Privacy Notice as required by the Health Portability and Accountability Act (HIPAA).

INSURANCE COVERAGE SPOUSE OR PARENT

If your insurance coverage is through the employer of your spouse or parent, we must have the policy holder's birth date as well as their social security number in order to file a claim to your insurance company. We apologize for any inconvenience this may cause and appreciate your understanding and compliance with this matter.

AUTHORIZATION TO RELEASE INFORMATION

RELEASE TO FAMILY MEMBERS: Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give consent to release this information to the family members indicated below. You have the right to revoke this consent in writing.

I authorize/allow Hugh Chatham Medical Group to release my medical and/or billing information to the following individual(s):

1. _____ _____ 2. _____ _____
(name) (relation to patient) (name) (relation to patient)

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE: Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Patient or Responsible Person Signature: _____ *Date:* _____ *Time:* _____

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PATIENT REGISTRATION

MEDICAL INFORMATION

Allergies: _____ Reactions: _____

CURRENT MEDICATIONS

Name of Medicine:	Dose (mg):	How Many Times Daily?:

MEDICAL HISTORY

Have you ever had any of the following:

____ Anemia ____ Blood Clot ____ Hepatitis ____ Pacemaker ____ Stroke
____ Anxiety ____ Cancer ____ High Blood Pressure ____ Seizure Disorder ____ Thyroid Disorder
____ Arthritis ____ Diabetes ____ Kidney Disease List any others: _____
____ Asthma ____ Emphysema ____ Liver Disease _____
____ Back Disorder ____ Heart Attack ____ Lupus _____

History of Hospitalizations: Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, do hereby consent and authorize _____
(Patient Name) (Practice Name)
to release to Hugh Chatham Medical Group all medical records relating to my (or my dependent child's) identity, diagnosis, prognosis and treatment. This may include psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, hepatitis, or drug and/or alcohol abuse.

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice of revocation to Hugh Chatham Medical Group, except to the extent that any action has already been taken on this release. Otherwise consent will remain in force for 90 days. Exclude the following information from the records released (if any): _____

TREATMENT OF A MINOR/DEPENDENT

This pre-consent form allows parents of minors or legal guardians of dependent adults to grant permission for other responsible adults to bring their child or dependent adult to our office for evaluation and treatment.

The undersigned parent/guardian of _____ Date of Birth _____does hereby empower and authorize the following named individuals:

1. _____ Relation to patient: _____ 3. _____ Relation to patient: _____
2. _____ Relation to patient: _____ 4. _____ Relation to patient: _____

Express permission to act as my agent to consent to and authorize medical evaluation and treatment for my above child/dependent. This authorization provides authority and power on the part of the above named individuals to give specific consent to any and all such evaluation, diagnosis, office treatment, immunization administration, anesthetic administration or surgical treatments which a physician, in the exercise of his/her best judgment, may deem advisable. This authorization includes hospital admission if such is deemed necessary by the physician.

Patient or Responsible Person Signature: _____ *Date:* _____ *Time:* _____

How did you hear about us? ____ **Website** ____ **Facebook** ____ **Friend/Family** ____ **Physician** ____ **Other**

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INFECTIOUS DISEASE SCREENING
HUGH CHATHAM MEDICAL GROUP

RECENT HISTORY

Have you recently lived in or traveled to a country with widespread disease transmission? _____ Yes _____ No

If yes, please list all countries: _____

Have you been in contact with an individual with confirmed infectious disease within the previous 21 days? _____ Yes _____ No

If yes, what disease(s) were you exposed to? _____

REVIEW OF SYSTEMS

Please check below if you are having any signs or symptoms.

____ Fever ____ Headache ____ Muscle Aches ____ Diarrhea

____ Fatigue ____ Weakness ____ Vomiting ____ Persistent Cough (longer than 1 week)

____ Other Suggestive Symptoms: _____

_____