The Family Doctor

1728 Fordham Boulevard - 151 Rams Plaza - Chapel Hill, North Carolina 27514 - (919) 968-1985

Patient Information

Patient's Name _____ (Last Name / First Name / MI) **Chart Number** _____

Birthdate _____ **Age** _____ **Sex** _____ **Marital Status** _____

Mailing Address _____ (Street / City / State / Zip Code)

Street Address (If Different) _____ (Street / City / State / Zip Code)

Home Phone ( ) _____ **Work Phone ( )** _____ ext. **Cell Phone ( )** _____

Employer _____ **Preferred Contact:** ☐ Cell ☐ Home ☐ Work

Work Address _____ (Street / City / State / Zip Code)

Please Make One (1) Selection For Each Category (Preferred Language, Ethnic Origin, and Race)

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ I'd rather not report

Ethnic Origin

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I'd rather not report

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ I'd rather not report

Social Security Number _____

Email Address _____
This is **ONLY** used for Updox.

☐ I do not have an email address

Billing Information and Guarantor Information (For Patients Under Age 18)

Responsible Party _____ (Last Name / First Name / MI) **Relationship** _____

Birthdate _____ **Age** _____ **Sex** _____ **Marital Status** _____

Billing Address _____ (Street / City / State / Zip Code)

Insurance Information

Subscriber's Name _____ (Last Name / First Name / MI) **Relationship** _____

Birthdate _____ **Sex** _____ **Social Security Number** _____

Street Address _____ (Street / City / State / Zip Code)

Employer _____ **Work Phone ( )** _____ ext

Work Address _____ (Street / City / State / Zip Code)

Emergency Contact

Contact's Name _____ **Phone ( )** _____ **Relationship** _____

Authorization to File Insurance

I certify that all the above information is correct. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I authorize payment of insurance benefits (otherwise payable to me) be paid directly to the North Carolina Family Doctor, P.A.

Signature _____ **Date** _____

How Did You Learn About Us?

- ☐ TFD Website - 11
- ☐ Other Internet - 14
- ☐ TFD Brochure - 6
- ☐ Friend/Family - 2
- ☐ School - 9
- ☐ Twitter - 8
- ☐ Phone Book - 1
- ☐ TFD Sign - 4
- ☐ Employer - 3
- ☐ Apartment - 12
- ☐ Facebook - 7
- ☐ Professional Referral - 5
- ☐ Hotel/Motel -13
- ☐ Other - 10
- ☐ Unknown - 99

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Authorization for Release of Information

Patient's Name _____ **Chart** _____
Last Name First Name MI

I authorize the NC Family Doctor, P.A. (TFD) to release protected health information, if necessary, about the above named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that TFD may need to discuss my medical condition and may need to share my medical records with any physican, physican extender, nurse, therapist, or other health care provider who is involved in my care.

	Yes	No
The Family Doctor may leave messages (for appointment remiders, lab, or x-ray results) on my home answering machine.	☐	☐
The Family Doctor may leave messages (for appointment reminders, lab or x-ray results) on my work answering machine.	☐	☐
The Family Doctor may leave messages (for lab and office notes) on my email.	☐	☐
I do not currently have an answering machine at home/work, but if I were to get one, The Family Doctor may leave messages.	☐	☐
The Family Doctor may leave messages for appointment reminders with others in my home.	☐	☐
If necessary, The Family Doctor may talk with my spouse or significant other about my medical condition or billing information.	☐	☐
This person's name is: _____		
If necessary, The Family Doctor may talk with my parent/caretaker about my medical condition or billing information	☐	☐
This person's name is: _____		

The Family Doctor may **may not** discuss my medical condition with: _____

Rights of the Patient

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information (PHI) to be disclosed as decribed in this document by sending written notification to:

Administrator, NC Family Doctor, 1728 Fordham Blvd, 151 Rams Plaza, Chapel Hill, NC 27514

I understand any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing.

This authorization shall be in effect until revoked by the patient.

Consent of Treatment

I hereby voluntarily consent to medical examinations, treatment and procedures which are deemed necessary in the opinion of my health care providers, including HIV tests, laboratory tests, and x-rays.

I understand that my medical information is strictly confidential and is protected by North Carolina General Statute 130A-143 and no guarantees or warrantees have been made to me concerning the results of the examination, treatments or procedures.

My signature acknowledges that I have been given the opportunity to ask questions about this consent form and I have the ability to refuse services

Signature _____ **Date** _____

Addendum for Patients Aged 12-18 Years (Must be signed by Parent/Guardian)

Pursuant to North Carolina General Statutes §90-21.5, a minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services related to the prevention, diagnosis and treatment of certain conditions: (1) Venereal diseases and other reportable diseases under GS §130A-135, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance. Disclosure to parents of the performance or non-performance of these services will not be made without the minor's written consent.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____ Relationship _____