Office Use - Input Info
Date:
Initials:

MRN:
Date:

DEMOGRAPHIC INFORMATION

All information is strictly confidential.

First Name: _____ MI: ____ Last Name: _____ Date of Birth: _____

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ SS#: _____

Gender: M F Martial Status: Married Single Divorced Widowed Other: _____

Race: Am Ind/Alaskan Black/Afr Am Pac Isl/Hawaiian White Other: _____

Ethnicity: Latino Non-Latino Language: English Spanish Other: _____

Contact Numbers: Work: _____ Cell: _____ Home: _____

Emergency Contact Information

I authorize the individual(s) listed below to have access to my personal medical information. I understand that this information is not limited to diagnosis, laboratory results, medication refills and information, and appointment times. I understand that by signature below indicates Carolina East Family Medicine is released from all legal responsibility that may arise from this authorization. I understand that Carolina East Family medicine assumes no responsibility for the use or misuse of my health information disclosed under this authorization.

Full Name: _____ Relationship: _____ Phone: _____

Additional Names: _____

Insurance Assignment and Release

I certify that I have insurance coverage with _____ and sign directly to the healthcare providers at Carolina East Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Carolina East Family Medicine may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services provided and determining insurance benefits or the benefits payable for related services.

Primary Medical Insurance	Secondary Medical Insurance
Ins. Company Name:	Ins. Company Name:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SS#:	Policy Holder's SS#:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Subscriber/Member ID:	Subscriber/Member ID:

Notice of Privacy Practices Consent

My signature below indicates that I have been given an opportunity to review a current copy of the Carolina East Family Medicine "Notice of Privacy Practices." My signature below means that I agree to allow Carolina East Family Medicine to use and disclose the patient's personal health information to carry our treatment, payment, and healthcare operations. If I revoke this consent, CEFM does not have to provide further health care services to the patient.

My signature below verifies that I understand and further agree to the Authorization for Use/Release of Health Information Policy, Notice of Privacy Practices Consent, and Insurance Assignment and Release as directed above.

_____ _____
SIGNATURE of Patient, Beneficiary, Guardian, or Representative Date

_____ _____
PRINTED NAME of Patient, Beneficiary, Guardian, or Representative Date

CEFM
Carolina East Family Medicine, PA

HEALTH HISTORY - Page 1

All information is strictly confidential.

MRN:
Date:

Name:	Date of Birth:

PLEASE COMPLETE THE FOLLOWING MEDICAL QUESTIONNAIRE

Reason for today's visit: _____

CURRENT COMPLAINTS (Please check symptoms you currently have)

General	Lung	Gastrointestinal	Muscle Joints	Psychological
___ Recent Illness	___ Chronic Cough	___ Blood in Stool	___ Muscle/Joint Pain	___ Anxiety
___ Weight Loss	___ Shortness of Breath	___ Persistent Diarrhea	___ Back Trouble	___ Depression
___ Weight Gain	___ Difficulty Breathing	___ Difficulty Swallowing	___ Difficulty Walking	___ Mood Swings
___ Excessive Sweat			___ Muscle Stiffness	___ Paranoia
Other:	Other:	Other:	Other:	Other:
Skin	**Cardiovascular**	**Genitourinary**	**Neurologic**	**Endocrine**
___ Easy Bruising	___ Chest Discomfort	___ Vaginal Bleeding	___ Blindness	___ Heat Intolerance
___ Rash/Hives	___ Ankle/Foot Swell	___ Blood in Urine	___ Fainting	___ Cold Intolerance
___ Changing Moles	___ Shortness of Breath	___ Frequent/Painful Urination	___ Seizures	___ Excess Thirst
___ New Moles			___ Alertness Decline	___ Lack of Energy
Other:	Other:	Other:	Other:	Other:

MEDICAL HISTORY (Please check medical conditions you HAVE currently or HAD in the past)

___ Heart Disease	___ Migraines	___ Anemia	___ COPD / Emphysema	___ Kidney Disease
___ Heart Attack	___ Stomach Ulcers	___ Bleeding Disorder	___ High Blood Pressure	___ Cancer:
___ Stroke	___ Sleep Apnea	___ Hepatitis A, B, or C	___ Psychiatric Problem	- _____
___ High Cholesterol	___ Goiter	___ HIV/AIDS		- _____
___ Diabetes	___ Glaucoma	___ Arthritis		- _____
___ Asthma	___ Depression	___ Anxiety Disorder		- _____

Other:

SURGICAL HISTORY (Please list any surgery you have had in the past along with the date below)

Surgery:	Date:

ALLERGIES TO MEDICATIONS (Please list below)

Medications:	Reaction:

Health History - Page 2

All information is strictly confidential.

MRN:
Date:

Name:	Date of Birth:

CURRENT MEDICATIONS (Please list ALL medications and/or supplements with doses you are currently taking)

Medication:	Dosage:

FAMILY HISTORY: (Please complete to the best of your knowledge)

___ Heart Disease ___ High Blood Pressure ___ Stroke ___ Diabetes ___ Arthritis ___ Kidney Stones	___ Breast Cancer Relation, Age: ___ Colon Cancer Relation, Age: ___ Ovarian Cancer Relation, Age: ___ Uterine Cancer Relation, Age: Other: Other:

WOMEN

Date of last menstrual period:	Number of children:	Contraceptives/HRT:
Age at first menstrual cycle:	Age at first live birth:	

Social History
Do you smoke tobacco? YES NO Packs per day: _____ # years: _____
Do you drink alcohol? YES NO Drinks per day: _____ per week: _____
Occupation: _____

Advance Care Plan
Do you have an Advance Care Directive (Do Not Resuscitate, DNR, or Living Will)? YES NO
Do you have a Durable Power of Attorney for Health Care or a Health Care Proxy appointed? YES NO
If YES, who is your Power of Attorney or Health Care Proxy? _____

Preferred Pharmacy: _____ Location: _____

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my physician if I have a change in health.

_____ _____
SIGNATURE of Patient, Beneficiary, Guardian, or Representative Date

_____ _____
PRINTED NAME of Patient, Beneficiary, Guardian, or Representative Date

MRN:
Date:

Payment Policy

Name:	Date of Birth:

The undersigned hereby agrees to reimburse Carolina East Family Medicine directly for any services and supplies provided to the patient.

If the patient's insurance company has not paid within 90 days of billing, the patient is responsible for the balance in full. Balances owed after insurance payment has been made, are due in full within 30 days, unless other arrangements have been made through our Insurance/Billing Department.

Please Note: All insurance is filed as a courtesy, and for our patient's benefit. The patient/guarantor is still responsible for all charges and payments. Any benefits quoted are estimates and should not be taken as a guarantee of insurance payment.

*It is not the responsibility of Carolina East Family Medicine to know the details of each member's policy. This is up to the patient/guardian/proxy to know the details of what procedure(s) his/her insurance does or does not cover. Any and all procedures completed by the Physician(s) and/or Clinical Staff Member(s) are in compliance with AMA (American Medical Association) Standard of Care guidelines, and the Physician(s)/Clinical Staff Member(s) will do everything in their power to follow these guidelines to provide all patients with the best possible care. It is the responsibility of the patient to be aware of their policy. Please keep in mind, if there are in questions about what type of services fall under a specific category, we are always here to help.

Patients without insurance are expected to pay in full, at the time of service. Payment is required unless arrangements have been made with the Insurance/Billing Department. The patient/guarantor understands that all amounts quoted are estimates and additional charges may incur during treatment or testing.

Unless otherwise instructed, we send all laboratory testing to Quest Diagnostics. Depending on the type of labs that are either requested, or have been recommended and agreed upon by the Physician, the patient may receive a separate bill from Quest Diagnostics. Due to certain insurance policies billing procedures and/or reimbursements, our facility may bill patient labs as Third Party, and the patient will receive a separate bill from Quest Diagnostics.

All insured patients must present their current eligibility cards and pay all co-pays, coinsurance, or estimated deductible fees at the time of check-in.

OFFICE FEES:

- Office Visit: Fee determined by patient's insurance. (If self-pay, this amount will be given to you prior to your appointment time/being seen by the physician.)
- Duplicate of Lost or Stolen Prescription (*IF this is granted and in accordance with our Controlled Substance Agreement*): $10
- Forms: One Page Forms: $10
- - Large Forms (ie FMLA, disability paperwork): $25
- Patient-Copy of Medical Records (after first request) on Disc or Hardcopy: $10
- No Show/Late Cancellation: As a courtesy to our patients, and understanding extenuating circumstances arise, we do not currently charge a No Show or Late Cancellation Fee. This is subject to change at any time at the discretion of management. We ask at this time for a courtesy call to inform our office of the need to cancel or re-schedule a patient's appointment.

The undersigned has read the above policy and certifies they are the patient, patient's legal representative, or duly authorized by the patient as the patient's general agent, to execute this consent to pay for services and accept its terms.

Patient/Guardian Signature _____ Date _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Charles Jahrsdorfer, MD
3282 Charles Blvd | Greenville NC 27858 | Phone: (252)756-3713 | Fax: (252)756-5920

Patients Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Obtain From: _____ Release To: _____

_____ _____

_____ _____

I authorize Carolina East Family Medicine to ☐ **Release** and/or ☐ **Obtain** information and copies of records pertaining to my medical care and treatment.

☐ I authorize the following health care information (check all that apply):

☐ All my health information

☐ My health information related to the following treatment/condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

Purpose of Request: ☐ Transfer of Care ☐ Personal ☐ Insurance ☐ Attorney ☐ Other: _____

Preferred Delivery Method: ☐ Fax ☐ Mail ☐ Hard Copy ☐ Disc

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES TWELVE MONTHS AFTER IT IS SIGNED OR ON: _____

When my information is used or disclosed pursuant to the on this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA PRIVACY RULE. I have the right to revoke this authorization in writing to the extent that Carolina East Family Medicine has acted in reliance upon it. My written revocation must be submitted to Carolina East Family Medicine, Attention: Privacy Officer at 3282 Charles Blvd, Greenville, NC 27858.