SAMPSON
CONVENIENT CARE
1004 Beaman Street, Clinton, NC
910.592.9113
www.SampsonRMC.org/Convenient

# 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 Convenient Care 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:
If diabetic, is your diabetes controlled by ☐ Insulin ☐ Pills

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

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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# 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) 590-0050**

I hereby authorize the release of my health information to Sampson Convenient Care. 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 Convenient Care.

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:_____

_____ _____ _____
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_____ _____
Witness Date

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# Medical Record/Information Release

I give permission to Sampson Convenient Care 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 Convenient Care 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 Convenient Care 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.

_____ _____ _____
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# Privacy Practice Acknowledgement

I _____, have received a copy of the Notice of Privacy Practices from Sampson Convenient Care.

_____ _____ _____
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:_____

_____ _____ _____
CC Staff Signature Date