SAMPSON REGIONAL
PROFESSIONAL SERVICES
Albert A. Verrilli, MD

603 Beaman Street, Suite 402, Clinton, NC
910.590.3397
www.SampsonRMC.org/Verrilli

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 Professional Services, DBA Albert Verrilli, MD 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) 592-1334.**

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

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:__________________

______________________________________ ________________ __________
Patient (Parent/Guardian/Power of Attorney) Signature Relationship Date

______________________________________ __________
Witness Date

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Medical Record/Information Release

I give permission to Sampson Professional Services, DBA Albert Verrilli, MD 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 Professional Services, DBA Albert Verrilli, MD 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 Professional Services, DBA Albert Verrilli, MD 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

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Privacy Practice Acknowledgement

I ____, have received a copy of the Notice of Privacy Practices from Sampson Professional Services, DBA Albert Verrilli, MD.

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:____

Staff	Signature	Date