Boiling Spring Lakes
FAMILY MEDICINE

Domenic Palagruto, DO • Karen Wood, MD • McKenzie Kline, PA-C

3599 George II Highway, Southport, NC 28461
910-845-3244 • fax 910-845-3276
www.bslfamilymedicine.com

NEW PATIENT PACKET

Date: _____

Patient Name: ❑ Mr. ❑ Dr. ❑ Mrs. ❑ Ms. ❑ Miss _____
First Middle (Maiden) Last

IF the patient is a child: Mother's Name: _____ Father's Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ❑ Male ❑ Female

Mother's Maiden Name: _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Address: _____
No. and Street or Route and Box Number City State Zip

Home Phone Number: _____ Work: _____ Cell: _____
Circle Preferred Number Above

Place of Employment: _____ Job: _____

Who is Responsible for the Charges? _____ Date of Birth: _____
This would be the patient, a parent, or the Person listed on the insurance card

Address of Responsible Party: _____

Name of Spouse: _____ Date of Birth: _____

Emergency Contact/Relationship to Patient: _____ Phone: _____
PLEASE DO NOT USE A NUMBER LISTED ABOVE AS EMERGENCY CONTACT NUMBER

Do you have any drug allergies? _____ Latex allergy? _____

Pharmacy Name/Location: _____ Phone Number: _____

INSURANCE INFORMATION

Please provide a copy of all insurance cards so that this office can submit claims

Do you have insurance? ❑ Yes ❑ No Which Plan do you have? _____

Do you have Medicaid? ❑ Yes ❑ No You must have your (or your child's) Medicaid card up to date at each visit OR YOU WILL BE EXPECTED TO EXPECTED TO PAY ON THE DAY OF THE VISIT.

Do you have Medicare? ❑ Yes ❑ No Which Parts? _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Boiling Spring Lakes Family Medicine (**Dr. Domenic Palagruto, Dr. Karen Wood, McKenzie Kline, PA-C**) of the Surgical and/or medical benefit, if any, otherwise payable to me for services rendered.

Signature of Insured or Parent/Guardian: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Boiling Spring Lakes Family Medicine (**Dr. Domenic Palagruto, Dr. Karen Wood, McKenzie Kline, PA-C**) to release any information acquired in the course of my examinations and/or treatment to my insurance carriers, third party payers, or others involved in processing and collection of any claims submitted on my behalf.

Signature of Patient or Parent or Guardian: _____

We invite you to frankly discuss any questions you have regarding services provided by this office at any time. Good medical care is based on a mutual understanding and open communication between physician and patient.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Practice Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be disclosed is as follows: (include dates where appropriate)

____ Complete Health Records
____ Physical Exam
____ Immunization records
____ Other (please specify) _____
____ Lab results/X-ray reports
____ Consultation reports

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Boiling Spring Lakes Family Medicine
3599 George II Highway
Southport, NC 28461
Phone: 910-845-3244

For the purpose of continuity of care.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

7. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFRI64.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information I can contact: _____

Privacy officer for: _____

_____ _____
Signature of patient or legal representative **Signature of witness**

_____ _____
Date **Date**

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243 and federal law 42 CFR, part II.)

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I, _____ [ ] ***Do*** [ ] ***Do Not*** authorize the doctors and staff of **Boiling Spring Lakes Family Medicine** to leave messages and/or test results on my answering machine or voicemail, even though my identity is not given on my recorded message.

I, _____ , agree to the above statement and consider it to be valid from the date signed unless I notify **Boiling Spring Lakes Family Medicine**, in writing, that I wish these agreements to be voided.

Date: _____ Patient/Guardian Signature _____

1,_____ , authorize the doctors and staff of **Boiling Spring Lakes Family Medicine** as defined above to discuss all aspects of my medical records with other family members or designated parties as listed below:

Name (please print)	Relationship to patient/phone number

Date	Patient/Guardian Signature	Witness

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Boiling Spring Lakes Family Medicine ***Notice of Privacy Practices*** has been provided to me for review.

I understand that the purpose of this notice is to inform me of my rights in regard to my Protected Health Information and also the ways in which the practice may use my Protected Health Information.

Patient or Representative Date

Boiling Spring Lakes Family Medicine

Please Print

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Mother's Maiden Name:** _____

Drug allergies (please include reaction): _____

_____

_____

Pharmacy of choice (please include location): _____

Current medications (include prescription, over the counter and herbal meds.) List dosage and frequency:

_____

_____

_____

_____

Hospitalizations & Surgeries (list dates if known): _____

_____

_____

Social History:

Tobacco Use: ❑ Never ❑ Former, year quit _____ ❑ Yes, how much? _____

Smokeless Tobacco Use: ❑ Never ❑ Former, year quit _____ ❑ Yes, how much?

Alcohol Use: ❑ None ❑ Rarely ❑ Socially ❑ Daily, how many? _____

Caffeine Use: ❑ None ❑ Daily, how many? _____ per day or _____ per week.

Street Drug Use: ❑ No ❑ Yes - what? _____

Have the following tests been performed elsewhere? (please list date)

EKG _____	Mammogram _____	Colonoscopy _____
PSA _____	Pap Smear _____	Bone density _____
Cholesterol _____	Tetanus Vaccine _____	Shingles vaccine _____
Pneumonia vaccine _____		

Other current physicians or specialists (name, specialty, address and phone number):

_____

_____

_____

Please indicate your family history in the boxes below:

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Living										
Deceased (age)										
Asthma										
Breast Cancer										
CAD (Heart Disease)										
Colon Cancer										
Diabetes										
Heart Attack										
High Cholesterol										
High Blood Pressure										
Lung Cancer										
Melanoma										
Ovarian Cancer										
Prostate Cancer										
Rheumatoid Arthritis										
Stroke										
Sudden Cardiac Death (under 50)										
Thyroid, High										
Thyroid, Low										
Uterine Cancer										
Other										

Any other family medical history: _____

_____

_____

_____

_____

Personal Medical History and Current Symptoms

Check current or past problems and indicate age when you had any of the symptoms

Weight:

- ❑ Loss _____
- ❑ Gain _____
- ❑ How much? _____

Eyes:

- ❑ Vision changes _____
- ❑ Last eye exam _____
  Name of doctor _____

Ears, Nose, Throat:

- ❑ Hearing loss _____
- ❑ Frequent sinus infections _____
- ❑ Frequent ear infections _____
- ❑ Prolonged hoarse voice _____
- ❑ Allergy symptoms _____

Dental:

- ❑ Last dental visit: _____
  Name of doctor _____

Respiratory:

- ❑ Chronic cough _____
- ❑ Asthma _____
- ❑ Pneumonia _____
- ❑ Bronchitis _____
- ❑ Shortness of breath _____
- ❑ Emphysema/COPD _____

Cardiac:

- ❑ Chest pains _____
- ❑ Palpitations _____
- ❑ Irregular pulse _____
- ❑ Heart disease _____
- ❑ Heart attack _____
  History _____
- ❑ Heart murmur _____
- ❑ High blood pressure _____
- ❑ Swollen ankles _____
- ❑ Leg pain when walking _____
- ❑ Varicose veins _____

Gastrointestinal:

- ❑ Difficulty swallowing _____
- ❑ Persistent nausea and vomiting _____
- ❑ Persistent diarrhea _____
- ❑ Constipation _____
- ❑ Rectal bleeding _____
- ❑ Dark and tarry stools _____
- ❑ Change in bowel habits _____
- ❑ Laxative use _____
- ❑ Heartburn _____
- ❑ Stomach ulcers _____
- ❑ Colon polyps _____
- ❑ Irritable bowel disease _____
- ❑ Ulcerative colitis _____
- ❑ Crohn's disease _____
- ❑ Hepatitis _____
- ❑ Diverticulosis _____
- ❑ Chronic abdominal pain _____
- ❑ Hiatal hernia _____

Genitourinary:

- ❑ Painful urination _____
- ❑ Urgency to urinate _____
- ❑ Waking up at night to urinate _____
  (more than twice a night) _____
- ❑ Enlarged prostate _____
- ❑ Kidney stones _____
- ❑ Frequent urinary tract infections _____
- ❑ Urine leakage _____
- ❑ History of sexual transmitted disease _____
- ❑ Herpes _____
- ❑ Sexual problem _____
  Describe _____

Gynecologic:

❑ Irregular periods _____
❑ Abnormal vaginal bleeding _____
❑ Painful periods _____
❑ Very heavy periods _____
❑ Frequent vaginal infections _____
❑ Abnormal pap smear _____

First day of last period:

(month, day, year) _____
❑ Birth control method _____

Pregnancies:

❑ Number _____
❑ Miscarriages _____
❑ Abortions _____
❑ Number of live births _____

Menopause:

❑ Hot flashes
❑ Night sweats _____
❑ Sleeplessness _____
❑ Moodiness _____

Breasts:

❑ Abnormal mammogram _____
❑ Breast mass _____

Musculoskeletal:

❑ Arthritis _____
Where _____
❑ Painful swollen joints _____
❑ Osteoporosis _____
❑ Broken bones _____
Where _____
❑ Gout _____
❑ Recurrent back pain _____
❑ Foot pain _____

Blood:

❑ Anemia _____
❑ Bleeding problems _____
❑ Blood clots _____
❑ Blood transfusion _____

Nervous System:

❑ Seizure disorder _____
❑ Numbness/tingling sensation _____
❑ Migraines _____
❑ Frequent headaches _____
❑ Tremors _____
❑ Lack of balance _____
❑ History of stroke or TIA _____

Psychiatric:

❑ Depression _____
❑ Anxiety _____
❑ Suicidal thoughts _____
❑ Mental illness _____
❑ Difficulty sleeping _____
❑ Alcoholism _____
❑ Drug abuse _____

Skin:

❑ Eczema _____
❑ Mole changes _____
❑ Rashes _____
❑ History of skin cancer _____
Where _____
❑ Hair loss _____
❑ Hives _____
❑ Shingles _____

Endocrine:

❑ Diabetes _____
❑ High thyroid _____
❑ Low thyroid _____
❑ Thyroid nodule _____

Cancer:

❑ No ❑ Yes
Type, year, treatment

_____
_____

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RECORD RELEASE TO OFFICE

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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7. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFRI64.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information I can contact: _____

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_____ _____

Signature of patient or legal representative **Signature of witness**

_____ _____

Date **Date**

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Date **Date**

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