



Domenic Palagruto, DO • Karen Wood, MD • Meredith Lewis, NP

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3599 George II Highway, Southport, NC 28461

910-845-3244 • fax 910-845-3276

*[www.bsifamilymedicine.com](http://www.bsifamilymedicine.com)*

**NEW PATIENT PACKET**

Patient Name: [Mr./Mrs./Miss] [Dr./Ms.] \_\_\_\_\_ Date: \_\_\_\_\_
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] EXPECTED TO You must have your (or your child's) Medicaid card up to date at each visit OR YOU WILL BE 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, Meredith Lewis, NP ) 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, Meredith Lewis, NP ) 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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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 \_\_\_\_\_

I, \_\_\_\_\_, 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.

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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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## 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

Lab results/X-ray reports

Physical Exam

Consultation reports

Immunization records

Other (please specify) \_\_\_\_\_

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 CFR164.524. 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.)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Boiling Spring Lakes Family Medicine

Social History Questionnaire

1. Over the past 2 weeks, how often have you been bothered by any of the following problems?

A. Little interest or pleasure doing things                      Yes    No

B. Feeling down, depressed or hopeless                      Yes    No

2. Do you live alone or with others?    Alone                      With others    Who: \_\_\_\_\_

3. Relationship status

Married   Single              Divorced   Separated              Widowed              Domestic Partner

4. How many children do you have? \_\_\_\_\_

5. Any changes in your family or social situation?                      Yes    No

6. Do you live in a single or multi-level home?                      Single                      Multi-level

7. What is your education level? \_\_\_\_\_

8. Are you currently employed?                      Yes    No

9. What is your occupation? \_\_\_\_\_

10. Do you drink alcohol?                      Yes    No

How much?    None                      Occasional    Moderate              Heavy

11. What is your exercise level?

None    Occasional    Moderate              Heavy

12. What is your general stress level?

Low    Medium              High

13. Smoking Status

Never Smoker

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Former Smoker      How long ago did you quit? \_\_\_\_\_

How much did you smoke? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_

Current Smoker      How much? \_\_\_\_\_

How many years have you smoked? \_\_\_\_\_

Do you chew tobacco? \_\_\_\_\_

14. Do you use illicit drugs or controlled substances?      Yes      No      What \_\_\_\_\_

15. Are you blind or do you have serious difficulty seeing?      Yes      No

16. Are you hard of hearing or deaf in one or both ears?      Yes      No

17. Are you able to care for yourself?      Yes      No

18. Do you have any difficulties with finding transportation?      Yes      No

19. Do you have difficulty doing errands alone?      Yes      No

20. Do you have difficulty dressing or bathing?      Yes      No

21. Do you have difficulty walking or climbing stairs?      Yes      No

22. Do you have difficulty concentrating, remembering things or making decisions?

Yes      No

23. Do you have an advanced directive?      Yes      No

24. Do you interact with people outside of your house daily?      Yes      No

25. Are you sexually active?      Yes      No