CONE HEALTH MEDICAL GROUP

Primary Care at Forest Oaks

Partnering for exceptional care.

4620 Woody Mill Rd., Suite G
Greensboro, NC 27406
(336) 907-3907 • Fax (336) 907-3910

Dear Patient,

We are delighted that you have selected us to be your health care provider. To ensure that we provide you with exceptional service with your healthcare and billing needs, please take a few moments to read and sign the following information.

Registration

Primary Care at Forest Oaks works on appointment/same day work in basis. Please call ahead for same day work in availability time. Office hours are 8:00 am - 5:00 pm Monday through Friday. The office is closed for business between the hours of noon - 1:00 pm and closed on the weekends. Please make note that there is a fee of $50.00 if you do not show for your scheduled appointment and for cancelled appointments if not notified 24 hours prior to your original appointment. **If you have 3 no shows you will be discharged from our practice.**

New patients should arrive 30 minutes prior to actual appointment time to fill out paperwork. If you are more than 10 minutes late for your appointment, we may ask that you reschedule your appointment. If you wait more than 10 minutes in the waiting room, please ask the receptionist if there is a delay in the physician's schedule.

Billing/Insurance

Please be advised that the billing and insurance filing of the services provided in our office is managed by the Billing and Profees Department. If you have any questions with regards to your account/balance please call 844-566-1324 (Toll Free).

Your insurance will be filed for all Office visits including Nurse Visits and a co pay will be collected at the time of service. All in house labs are referred to Solstas Laboratory Network.

As a courtesy, we will file a claim to your insurance company, and it is your responsibility to provide proof of insurance coverage. If you cannot provide proof of insurance, you will be responsible for payment of the bill at the time of your visit.

Please make note that it is the patient's responsibility to notify our office if your visit is related to a Worker's Compensation Case and if you have notified your present employer of the injury. We will file with your insurance until you advise us that your employer will cover your visit as a Worker's Compensation incident.

Visit with your Doctor

Please bring all medications, vitamins, mineral pills, etc., you take to each visit. If you need your medicine refilled, please call your pharmacy/drug store first. Please allow 24 hours for all refill requests called in to our office.

If you need to reschedule a referral visit please call the Specialist Office directly that will be provided to you by the referral coordinator. To obtain your results from a referred Specialist Office please call their office directly for results. We will contact you with all STAT labs and abnormal results.

Emergency Contact/After Hours

Please call 911 or go to the nearest Emergency Room if you have a life-threatening emergency. Otherwise, dial (336) 907-3907 to reach the on call physician. Please make note that no prescriptions will be filled after regular business hours.

Customer Service

Your feedback is important to us as our team strives to be the leading choice as your Primary Care Provider.

Thank you for your patronage,

Cone Health Primary Care at Forest Oaks Team

_____ _____

Patient Signature Date

_____ _____

Guardian/Power of Attorney Signature Date

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Name: _____ Age _____
Last Name First Name Middle Initial

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female SSN: _____

Home Address: _____
Street Address Apt # City/State/Zip

Mailing Address: (If different from above) _____
Street Address or PO Box City/State/Zip

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Language: ☐ English ☐ Spanish ☐ Other _____ Needs interpreter: ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Race: ☐ Asian ☐ African American ☐ American Indian ☐ White ☐ Other ☐ Unknown

Primary Care Provider: _____ Preferred Pharmacy: _____

Emergency Contact Information

Name: _____
Last Name First Name Middle Initial

Home Address: _____
Street Address Apt # City/State/Zip

Relationship to Patient: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Work Phone: (_____) _____

Patient Employment Information

Employer: _____ Occupation: _____

Check One: ☐ Full-Time ☐ Part-Time Work Phone: (_____) _____

Work Address: _____
Street Address City/State/Zip

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company: _____	Insurance Company: _____
SSN# of Policy Holder _____	SSN# of Policy Holder _____
DOB of Policy Holder _____	DOB of Policy Holder _____
Policy No: _____	Policy No: _____
Group No: _____	Group No: _____

The undersigned hereby authorizes said Provider(s) to release all information pertaining to patients' treatment to his/her insurance company or companies and to any other physician or health care provider to whom the undersigned may be referred. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including medical, private insurance, and other health plans to: Cone Health Medical Group Primary Care at Forest Oaks.

_____ _____
Patient/Guardian Signature Date

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ADVANCED DIRECTIVES

Do you have Advanced Directives?

☐ Yes

☐ No

If yes, please mark the appropriate box:

☐ DNR ☐ Living Will ☐ Healthcare Power of Attorney

Would you like additional information?

☐ Yes

☐ No

Name: _____ DOB: _____

CONE HEALTH MEDICAL GROUP **Primary Care at Forest Oaks**
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Name _____ **Date** _____

ADULT MEDICAL HISTORY FORM

Your answers on this form will help your provider better understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates. Thank you!

Age _____ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns I would like to discuss if there's time: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
__Fevers/sweats/weakness
__Unexplained weight loss/gain
Eyes
__Change in vision
Ear/Nose/Throat/Mouth
__Difficulty hearing/ringing in ears
__Hay fever/allergies
Cardiovascular
__Chest pain/discomfort
__Palpitations
Breast
__Breast lump/nipple discharge
Respiratory
__Cough/wheeze
Gastrointestinal
__Blood in bowel movement
__Nausea/vomiting/diarrhea
Genitourinary
__Nighttime urination
__Leaking urine
__Unusual vaginal bleeding
__Discharge: Penis or vagina
Musculoskeletal
__Muscle/joint pain
Skin __Rash/new or change in mole
Neurological
__Headaches
__Memory loss
Psychiatric
__Anxiety
__Sleep problem
__Depression
Blood/Lymphatic
__Unexplained lumps
__Easy bruising/bleeding
Other
__Concern with sexual function

In the past month, have you had little interest or pleasure in doing things or felt down, depressed or hopeless: ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	**Dose (e.g. mg/pill)**	**How many times per day**

ALLERGIES or REACTIONS TO MEDICINES:

_____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ Measles _____
Pneumovax (pneumonia) _____ Rubella _____ Tetanus (Td) _____
Varicella (chicken pox) shot or illness _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date _____ Abnormal? ☐ Yes ☐ No

Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Abnormal? ☐ Yes ☐ No

Women: Mammogram _____ Date _____ Abnormal? ☐ Yes ☐ No Pap Smear _____ Date _____ Abnormal? ☐ Yes ☐ No

Men: PSA (prostate) _____ Date _____ Abnormal? ☐ Yes ☐ No

PLEASE TURN OVER

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems with dates.

_____ Heart disease
specify type _____
_____ Heart attack

_____ High blood pressure
_____ Diabetes
_____ Other: (specify) _____

_____High cholesterol
_____ Thyroid Problem

SURGICAL HISTORY: Please list all prior operations with dates: _____
_____
_____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____
Cancer, specify type _____
Heart Attack _____
Depression/Suicide _____
Diabetes _____

High Cholesterol _____
High Blood Pressure _____
Stroke _____
Other _____
Other _____

SOCIAL HISTORY

Tobacco Use
Cigarettes ☐ Never ☐ Quit date _____
☐ Current Smoker: packs/day _____# of yrs _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use
Do you drink alcohol? ☐ Yes ☐ No # drinks/week _____
Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use
Do you use any recreational drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity
Sexually active: ☐ Yes ☐ No ☐ Not currently
Current sex partner(s) is/are: ☐ Male ☐ Female
Birth control method: _____ ☐ None Needed
Have you ever had any sexually transmitted disease (STDs)?
☐ Yes ☐ No
Are you interested in being screened for sexually transmitted disease? ☐ Yes ☐ No

Other Concerns
Caffeine Intake: ☐ None ☐ Coffee/tea/soda _____ cups per day
Weight: Are you satisfied with your weight? ☐ Yes ☐ No
Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor
Do you eat or drink 4 servings of dairy or soy daily or take calcium supplements? ☐ Yes ☐ No
Exercise: Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
Safety: Do you use a bike helmet? ☐ Yes ☐ No ☐ NA
Do you use seatbelts constantly? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Have you ever been abused? ☐ Yes ☐ No
Do you have a gun in your home? ☐ Yes ☐ No

SOCIOECONOMICS:
Occupation: _____ Employer: _____
Years of education/highest degree: _____
Marital Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed Other: _____
Spouse/partner's name: _____ Number of children/ages: _____
Who lives at home with you? _____

WOMEN'S HEALTH HISTORY:
# of pregnancies _____ # of deliveries _____ # of abortions _____ # of miscarriages _____

1st day of most recent period: _____

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Medical Records Release Form

(from another practice to ours)

Patient Name _____ Date of Birth _____

Telephone _____ Social Security # _____

Address _____

I hereby authorize the use or disclosure of my individual identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I authorize Cone Health Medical Group Primary Care at Forest Oaks to request progress notes, labs, x-rays, procedure notes and immunizations from the last 1 year.

Please indicate if you would like your records once we receive them. ☐ Yes ☐ No

Please request records from:

Dr. _____ Phone:_____

Address: _____ Fax:_____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless revoked earlier, this authorization will expire on _____/_____/_____ .
Initials: _____

b. I understand that I may revoke this authorization at any time by notifying Cone Health in writing, but if I do, it won't have any effect on any actions Cone Health took before it received the revocation.
Initials: _____

c. I understand that Cone Health cannot make me sign this authorization as a condition to receive treatment from Hospital except:
   1. When Cone Health provides me with research-related treatment, or
   2. When Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials: _____

d. **I understand there may be a charge for reproduction of medical records/films/tapes.**
Initials: _____

Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Authorized Representative Date

_____ _____
Witness Signature Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION