DAYSPRING FAMILY MEDICINE

Welcome New Patient!

Please arrive 30 minutes prior to your appointment time and bring your **completed New Patient Packet.** Please bring the following with you: **insurance card, co-pay and all prescription medicine bottles and over the counter medicines you take and shot record for all patients under 18 years of age.**

APPOINTMENTS

We ask that you arrive at your appointment on time and that you bring your insurance card, medication or a list of medication and your co-pay. If you arrive late for your appointment or without your insurance card or co-pay, we will reschedule your appointment. To be respectful of other patients, please call our office if you are unable to attend or if you are running late.

CO-PAYS

All co-pays and balances are expected at the time of service. You are financially responsible for any services not covered by your insurance. There is a $25.00 service fee on all returned checks.

COMPLETION OF FORMS/LETTERS/MEDICAL RECORDS

We understand that various forms or letters may be required to assist you with your healthcare needs. Please allow 7-10 business days for completion of requested forms. There is a $25 fee for FMLA and Disability forms. Medical record requests must be in writing.

PRESCRIPTION REFILLS

For refills on your prescriptions, you must contact your pharmacy first. Your pharmacy will then contact us for the refill. Please allow us 48hours (about 2 days) to refill your prescriptions.

PATIENT PORTAL

We strongly encourage you to activate your Portal, which can provide a quick and easy method for communicating with our office.

INSURANCE

It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could delay insurance payment or cause denial of insurance payment. If applicable, you will be billed for services not covered by your insurance. Please contact your insurance company if you have any questions.

EMERGENCIES

We may be reached by phone at 336-623-5171 starting at 8am. If you have a medical emergency after office hours, please call UNC-R Hospital at 336-623-9711 and ask for the on-call Provider to be paged. The OnCall Provider will call you back within 30 minutes, if not please call the hospital to have them paged again.

PATIENT PRINTED NAME ____
DATE OF BIRTH ____
SIGNATURE (RESPONSIBLE PARTY) ____
DATE _________________

DAYSPRING FAMILY MEDICINE **ADULT MEDICAL HISTORY FORM**

NAME: ________________________ DATE OF BIRTH: _____________________________

MEDICATIONS – List all medications you take, prescription and non-prescription, and the dosage.

MEDICATION NAME	DOSAGE

MEDICATION AND FOOD ALLERGIES – List all known allergies (drug, food, animals)

SURGERIES – List all surgeries, date of surgeries and surgeon.

OPERATION	DATE	SURGEON

HOSPITALIZATIONS – List the date and reason for each hospitalization

YEAR	HOSPITAL/CITY/STATE	REASON FOR HOSPITALIZATIONS

PERSONAL MEDICAL HISTORY–Please indicate whether you have had any of the medical conditions

CONDITION	DATE OF ILLNESS	CONDITION	DATE OF ILLNESS
Alcoholism		Heart Attack	
Anxiety		High Blood Pressure	
Arthritis		High Cholesterol	
Asthma		Kidney Disease	
Blood clots, bleeding disorder		Migraine headaches	
Cancer		Seizure Disorder	
Congestive Heart Failure		Stroke	
Depression		Thyroids Problems	
Diabetes		Ulcer	
Emphysema		other	

GYNECOLOGICAL HISTORY (WOMEN ONLY)

WHEN WAS YOUR LAST PERIOD? ____
AT WHAT AGE DID YOU STOP HAVING PERIODS? _______________________________________
DO YOU HAVE ANY CONCERNS ABOUT YOUR PERIODS? ___________________________________
HOW MANY CHILDREN DO YOU HAVE? ____
WHEN WAS YOUR LAST PAP SMEAR? ____
WHEN WAS YOUR LAST MAMMOGRAM? ____
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ____________________________________
HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? __________________________________

SEXUAL HISTORY:
Are you sexually active? ______________ Birth control method: ________________________________
Have you ever had a sexually transmitted disease? ____
Do you have any concerns about possible exposure to sexually transmitted diseases? ______________
____

FAMILY HISTORY – Please indicate what/if any family members have had any of the medical conditions

CONDITION	DATE OF ILLNESS	CONDITION	DATE OF ILLNESS
Alcoholism		Heart Attack	
Anxiety		High Blood Pressure	
Arthritis		High Cholesterol	
Asthma		Kidney Disease	
Blood clots, bleeding disorder		Migraine headaches	
Cancer		Seizure Disorder	
Congestive Heart Failure		Stroke	
Depression		Thyroids Problems	
Diabetes		Ulcer	
Emphysema		other	

SOCIAL HISTORY:
TOBACCO USE: Currently use ___________ Quit ___________ Never used ____________
If using or used answer the following:
what type of tobacco product: ____
Amount per day: ______________________ Number of years: ________________________
Tobacco cessation ever discussed: ____
Secondary smoke exposure: ____
DRUG USE: Do you use any recreational drugs (marijuana, cocaine, meth, etc)? __________________
Have you used any recreational drugs in the past? ___________________________
OCCUPATION: ____
EDUCATION COMPLETED: ____
MARITAL STATUS: ____
NUMBER OF CHILDREN: ____

SAFETY:
Do you wear a seatbelt? ___________________ Do you wear a bike helmet? ________________
Is violence at home a concern? _____________ Do you feel safe in your current relationship? __________
Do you have a gun in your home? ___________ Do you have a Living Will? ______________________
Do you have a Healthcare Power of Attorney? ______
Do you have any communication concerns? ________ If so, please explain __________________________
____

Dayspring Family Medicine
723 South Van Buren Rd Suite B| Eden, NC 27288
336-623-5171 phone 336-627-5747 fax

REQUEST FOR MEDICAL RECORDS

PATIENT NAME: ____
DATE OF BIRTH: _____________________ SOCIAL SECURITY NUMBER: _________________________
FULL ADDRESS: ____
PHONE NUMBER: ____

I AUTHORIZE DAYSPRING FAMILY MEDICINE TO:
___ Request my health records from: ____ Release my health records to:

PROVIDER/FACILITY: ____
ADDRESS: ____
PHONE: __________________________________ FAX: _____________________________________

Information to be released:

___ All records	**___ History & Physical**	**___ Hospital Reports/notes**
___ Lab/Pathology reports	**___ Operative Reports**	**___ Imaging reports**

Date(s) of service requested: ____
Reason for request: ____

I understand that:
This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not. This authorization is valid for one year from the date signed unless an earlier date is specified here: ________. I may revoke/withdraw this authorization at any time by providing written notice; however, revocation/withdrawal will not apply to any previous release information. Once my protected health information is disclosed as requested, it may no longer be protected by federal and state privacy laws. The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Patient signature or Representative: ____
Patient Name: ____
Relationship to Patient: ____
Date: ____

DAYSPRING FAMILY MEDICINE **CONSENT/AUTHORIZATION FORMS**

Treatment of Minor:
I give permission for my child to be medically evaluated and treated at Dayspring Family Medicine in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation. I accept responsibility for any charges that insurance may not cover.
I give permission to Dayspring Family Medicine to give any immunizations that are needed as discussed by your Provider.

Immunizations:
Dayspring Family Medicine is required by North Carolina law to administer vaccines to all healthy infants, children and adolescents at the recommended dosing schedule set by the NCIP. The only exemptions are Religious and/or Medical.

Insurance:
I give Dayspring Family Medicine permission to file my insurance.

Medication History:
I give permission to Dayspring Family Medicine to access my pharmacy benefits data electronically through RxHub.

Appointment Reminders:
Our office will contact you to remind you of upcoming appointments. You may receive a reminder by telephone, voice mail, text message or email.

Release of Information:
I give Dayspring Family Medicine permission to discuss my personal health information with the individuals listed below. This authorization will be effective on the date below and will remain in effect until revised or revoked. This authorization can be revoked at any time, either verbally or in writing.

____

____

____

Notice of Privacy Practices:
I certify that I have been offered and/or received a copy of the Privacy Practice Notice. I consent to the uses and disclosures of my health information as outlined in the Notice.

Patient Name: ____

Date of Birth: ____

Patient Signature: ____

Responsible Person Name/Relationship: ____________________________________

Date: ____