CAROLINAS URGENT and PRIMARY CARE

PATIENT INFORMATION					
NAME		SS#	BIRTHDATE	LANGUAGE	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP				
DAY OR CELL PHONE #	HOME PHONE #	EMAIL ADDRESS			
PRIMARY CARE PROVIDER IF NOT CAROLINAS URGENT & PRIMARY CARE	ETHNICITY/ RACE	CONTACT PREFERENCE (circle one) PHONE EMAIL MAIL			

RESPONSIBLE PARTY INFORMATI ON (PARENT OR GUARDIAN)					
NAME		SS#	BIRTHDATE	LANGUAGE	GENDER
LOCAL ADDRESS	CITY, STATE, ZI P				
DAY PHONE #	HOME PHONE #	EMAIL ADDRESS			
HOW DID YOU HEAR ABOUT OUR PRACTICE? Circle one: Billboard Insurance Friend Family Social Media Phone Book Other		NAME AND TELEPH ONE NUMBER OF EMERGENCY CONTACT			

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY			
POLICY NUMBER		IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE	
NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE			
NAME OF INSURANCE COMPANY			
POLICY NUMBER		IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE	
NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

1. **PAYMENT AUTHORIZATION:** I hereby authorize payment for all services rendered by Carolinas Urgent and Primary Care to be made directly to Carolinas Urgent and Primary Care from my insurance company or from the proceeds of a personal settlement.
2. **TREATMENT AUTHORIZATION:** I hereby authorize treatment to be rendered by the doctors and medical staff of Carolinas Urgent and Primary Care.
3. **RELEASE OF INFORMATION AUTHORIZATION:** I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me/child to release and such information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Representative: _____ Date: _____

Thank you for choosing us for your healthcare needs, are you coming to us for:

PRIMARY CARE or URGENT CARE

CAROLINAS URGENT and PRIMARY CARE

HEALTH HISTORY FORM

Today's Date: _____ Age: _____

Date of last physical exam (and/or pap smear): _____

List any known allergies: _____

Date of last flu shot: _____ Date of last tetanus shot: _____ Date of last pneumonia shot: _____

What is the reason for your visit? _____

SYMPTOMS: Check symptoms you currently have

General

□ Anxiety
□ Bipolar Disorder
□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Nervousness
□ Numbness
□ Seizure
□ Sweats

Gastrointestinal

□ Appetite Poor
□ Bloating
□ Bowel Changes
□ Constipation
□ Diarrhea
□ Excessive Hunger
□ Excessive Thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal Bleeding
□ Stomach Pain
□ Vomiting
□ Vomiting Blood

Date of last colon cancer screening?_____

Eye, Ear, Nose, Throat

□ Bleeding gums
□ Blurred Vision
□ Crossed Eyes
□ Difficulty Swallowing
□ Double Vision
□ Earache
□ Ear Discharge
□ Hay Fever
□ Hoarseness
□ Loss of Hearing
□ Nosebleeds
□ Persistent Cough
□ Ringing in Ears
□ Sinus Problems
□ Vision – Flashes

Men Only

□ Breast Lump
□ Erection Difficulties
□ Lump in Testicles
□ Penis Discharge
□ Sore on Penis
□ Other

Women Only

□ Abnormal Pap
□ Bleeding between periods
□ Breast Lump
□ Extreme Menstrual Pain
□ Painful Intercourse
□ Vaginal Discharge

Date of last Period: _____
Pap:_____
Mammogram:_____
Are you pregnant?_____

Muscle/Joint/Bone

Pain, weakness or numbness in:

□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

Cardiovascular

□ Chest Pain
□ High Blood Pressure
□ Irregular Heart Beat
□ Low Blood Pressure
□ Swelling of ankles
□ Poor Circulation
□ Rapid Heart Beat
□ Varicose Veins

Skin

□ Sore that won't heal
□ Rash
□ Bruise Easily
□ Hives
□ Itching
□ Change in Moles

Genito-Urinary

□ Blood in urine
□ Frequent Urination
□ Lack of bladder control
□ Painful Urination

CAROLINAS URGENT and PRIMARY CARE

CONDITIONS: Check conditions you currently have or have had in the past year

□ AIDS	□ Chemical Dependency	□ High Blood Pressure	□ Positive TB Test
□ Alcoholism	□ Chicken Pox	□ High Cholesterol	□ Prostate Problem
□ Anemia	□ Diabetes	□ HIV Positive	□ Psychiatric Care
□ Anorexia	□ Emphysema	□ Kidney Disease	□ Rheumatic Fever
□ Appendicitis	□ Epilepsy	□ Liver Disease	□ Scarlet fever
□ Arthritis	□ Glaucoma	□ Measles	□ Stroke
□ Asthma	□ Goiter	□ Migraines	□ Suicide Attempt
□ Bleeding Disorders	□ Gonorrhea	□ Miscarriage	□ Thyroid Problems
□ Blood Transfusion	□ Gout	□ Mononucleosis	□ Tonsillitis
□ Breast Lump	□ Heart Disease	□ Multiple Sclerosis	□ Tuberculosis
□ Bronchitis	□ Hepatitis	□ Mumps	□ Typhoid Fever
□ Bulimia	□ Hernia	□ Pacemaker	□ Ulcers
□ Cancer, Type _____	□ Herpes	□ Pneumonia	□ Vaginal Discharge
□ Cataracts			□ Venereal Disease

# of Pregnancies: _____ # of Deliveries: _____ # of Miscarriages: _____ # of Abortions _____

Hospitalizations (Date, Reason, Outcome): _____

_____

Surgeries (Date, Types): _____

_____

Fractures, Serious Injuries: _____

Occupation: _____

Tobacco type _____How much per day?_____Age started_____ Age stopped_____

Alcohol type_____ How much per day?_____Age started_____ Age stopped_____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS List medications you are currently taking

_____

_____

_____

_____

Patient's Signature _____ Date_____

CAROLINAS URGENT and PRIMARY CARE

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death	Circle if blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer, Type:_____	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney	
					Tuberculosis	
Children					Other	

Other information you feel is important for the doctor to know about you:

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

CAROLINAS URGENT and PRIMARY CARE

Informed Consent & Controlled Medication Use Agreement

Patient Name: _____ Date of Birth:_____ I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.
2. I will take or allow my dependent child to take the medication only as prescribed by my Carolinas Urgent and Primary Care provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.
3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).
4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:

   _____
5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.
6. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
7. I understand that Carolinas Urgent and Primary Care participates in North Carolina Controlled Substances Registry. Patient prescription history will be reviewed and any discrepancies may result in dismissal from the practice.

8. **Refills will be given only during office hours with three business-days advance notice**. If my controlled medication(s) is/are lost, misplaced or stolen or if I finish them earlier than prescribed, they will not be replaced.
9. I will meet regularly with my provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my medication(s) being filled.
10. I understand that my provider or child's provider, may require specialist evaluation of my condition and treatment and I agree to keep appointments when my provider refers me. New patients who are referred to pain management or psychiatry will have three months to establish care with the specialist.
11. Success in treatment is measured by my ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that my provider may change or discontinue this medication if there is no longer evidence that I am receiving a reasonable therapeutic benefit from the medication or that I am no longer a good candidate to continue the medication(s).
12. I agree to taper my dose of the controlled medication(s) to determine their effectiveness on request of my provider.
13. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.
14. I agree to store my medications in a secure location.
15. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.
16. I agree to a blood or urine test for drug analysis at any time it is requested by the provider or child's provider. Random drug and alcohol screens are for my protection. I understand that my use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medication(s).
17. I agree that I will not give, sell or in any way distribute prescribed medications to others.
18. I agree I will not in any way attempt to forge or alter a prescription.
19. I agree to bring my medication(s) to the office to be counted if requested.
20. I agree that I will not verbally abuse clinic staff.
21. If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from Carolinas Urgent and Primary Care.
22. I understand that Carolinas Urgent and Primary Care has an on-call provider and an Urgent Care to address urgent concerns about prescribed medications that may arise during non-clinic hours. After-hours access information can also be obtained at www.thejacksonvilleclinic.com.

Additional Conditions and Information for Patients prescribed Opioid (Narcotic) Pain Medications:

a. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

b. I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals my treatment plan. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.
c. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.
d. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, pseudo non-addiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated does of opioid medication.
e. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.
f. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I think I may be pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.
g. I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an acute or sub-acute condition or for a specific timeframe such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.
h. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.
i. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient (or Parent/Guardian) Signature	*Date*
Prescriber Signature	*Date*