CAROLINAS URGENT and PRIMARY CARE

CAROLINAS CENTER for SURGERY

Casey Carter, RN, MSN, FNP-C

Metabolic Weight Management

Patient Registration Form

Patient Name:_____DOB:_____Date:_____

Height:_____Weight:_____SSN#:_____E-Mail:_____

Physical Address:_____

P.O. Box:_____City:_____State:_____ZipCode:_____

Home Phone:_____Cell:_____Work:_____

Preferred Pharmacy:_____Location:_____

How did you hear about our office: _____

Emergency Contact

Name: _____Relationship:_____Phone:_____

Referring Doctor: _____ Primary Care Physician: _____

Reason for Visit: _____

Medical Conditions (Please list ALL medical problems)

_____

_____

Primary Insurance Company:_____

Policy #_____Group #_____

Subscriber (if not the patient): _____DOB: _____

SSN#_____ 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 the medical information about me/my child to release such information needed to determine these benefits or the benefits payable for related services.

Signature or Patient or Representative: _____ Date: _____

Allergies:

Allergy to Latex: ☐ YES ☐ NO
Reaction:_____

Tobacco Use: ☐ YES ☐ NO Type:_____How Much:_____Date Quit:_____

Alcohol Use: ☐ YES ☐ NO How Often:_____

Illicit Drug Use: ☐ YES ☐ NO Type:_____Frequency:_____

When was your last bilateral mammogram (Female Only):_____

When was your last menstrual cycle:_____

Medication List: (Prescription & OTC, Please list dosage & frequency) WE WILL BE GLAD TO MAKE A COPY OF ANY LIST THAT YOU HAVE

MEDICATION	DOSAGE	FREQUENCY

Surgeries: (List ALL previous surgeries, dates or age of operation) WE WILL BE GLAD TO MAKE A COPY OF ANY LIST THAT YOU HAVE

SURGERY	DATE/AGE OF OPERATION

Family History Diabetes: ☐ NO ☐ YES:_____

Family History of Heart Disease: ☐ NO ☐ YES:_____