

Dean Internal Medicine
New Patient Intake Form

(Please have Insurance and ID cards as well as list of medications ready for us to copy)

Full Name: _____
DOB: ____ - ____ - ____ Social Security #: _____ (for insurance purposes)
Address: _____ Zip Code: _____
Marital Status: _____ Sex: Male or Female
Home Phone: _____ Cell #: _____ Work #: _____
Email Address: _____
Student? Y or N Employed? Y or N Full time Part time Retired Other _____

How did you hear about our office: _____

Insurance Information

Primary Insurance: _____
Secondary Insurance: _____

Other Information

List all providers involved in your care:

Name: _____	Specialty: _____	PH# _____
Name: _____	Specialty: _____	PH# _____
Name: _____	Specialty: _____	PH# _____

Your Pharmacy Name: _____ Pharmacy Phone: _____

If you have a mail order pharmacy, list here: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Do you have Advanced Directives? (examples: Living Will, Power or Attorney etc.)

Yes No I have no idea what that means

If Yes, we will need a copy of documents for your permanent records.

I authorize and hereby assign all medical benefit payments from any and all medical insurance or health plans belonging to me to Dean Internal Medicine. I understand I am financially responsible for all charges whether paid by insurance. I authorize Dean Internal Medicine to use and release all information necessary to secure payment.

Printed name of Patient/Legal guardian: _____

Signature of Patient/Legal guardian: _____ Date: _____

CONSENT FOR SERVICES

Dean Internal Medicine – 1409 Yanceyville St Ste C – Greensboro NC 27405 (336) 954-1007

Name: _____

Please initial each applicable item, sign and date below.

_____ General Consent: I consent to medical care at *Dean Internal Medicine*. This includes needed lab work and procedures performed in office. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. I agree that *Dean Internal Medicine* is not responsible for any loss or damage to my property.

_____ Your health information may be available to other healthcare or home health providers who provide care for you through the NC HealthConnex, or other health information exchanges. If you do not want your electronic medical record to be available to other providers through the health information exchange, contact our office to opt out. You may prevent your health information from being available through NC HealthConnex by asking for an opt out form to sign. Or you may opt out online at <https://hiea.nc.gov/patients>

_____ Acknowledgement of Receipt of Notice of Privacy Practices - I have been provided with a copy of *Dean Internal Medicine Notice of Privacy Practices*. I know that the Notice may be changed at any time. I may get a new copy of the Notice by asking for a copy.

_____ Financial Responsibility: I agree to pay for all medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. I assign all of my rights and claims for payment under any health insurance plan to *Dean Internal Medicine* and any other treating providers and/or their agents to act for me in getting payment for services provided. *Dean Internal Medicine* reserves the right to deny services to patients with delinquent accounts.

_____ I give permission to be contacted for appointment reminders, referrals, treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message.

I understand and agree with the above information. This consent is valid for three (3) years.

Signature: _____

Date: _____

List names of people you permit to discuss your care and treatment with:

NEW PATIENT MEDICAL HISTORY FORM



Full Name: _____

Date: _____

Birth Date: _____

Age: _____

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS <i>(Please list ALL)</i>	DOSE <i>(Mg., pill, etc.)</i>	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax (<i>Pneumonia</i>):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (<i>Shingles</i>):	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: _____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: _____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____

DOB: _____



OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N <i>(If no sexual history, please continue to Exercise)</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
EXERCISE	Do you exercise regularly? Y N <i>(If you answered no, please move to Sleep)</i>	
What kind of exercise?		Duration: How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night <i>(or during the day, if working night shift)</i> ?	
DIET	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____

DOB: _____

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION		CARDIOVASCULAR		SKIN	
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis	Gastrointestinal			Wound
	Fatigue		Abdominal distention	ALLERGY/IMMUNO	
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
HEAD, EAR, NOSE & THROAT			Blood in stool		Immunocompromised
	Congestion		Constipation	NEUROLOGICAL	
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling	ENDOCRINE			Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure	Genitourinary		HEMATOLOGIC	
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis	PSYCHIATRIC	
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
EYES			Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
RESPIRATORY			Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness	MUSCULAR			
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name: _____

DOB: _____

AUTHORIZATION OF RELEASE / REQUEST OF HEALTH INFORMATION

Dean Internal Medicine – 1409 Yanceyville St – Ste C – Greensboro NC 27405 – Ph: (336)954-1007 Fax: (336)954-1183

I (print name) _____

Date of birth: _____ Phone: _____

voluntarily consent to authorize my health care provider **DEAN INTERNAL MEDICINE** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be **Requested from** / **Released to** the following recipient(s):

Name: _____

Address: _____

Phone: _____

Purpose: I authorize the Release/Request of my health information for the following specific purpose:

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹
- Only the following records or types of health information:

Term: I understand that this Authorization will remain in effect:

From One year from date of this Authorization signature. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to **Dean Internal Medicine**. The revocation will be effective immediately upon my health care provider's receipt of my written notice except to the extent that the Practice has already made disclosure in reliance upon my prior consent.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Signature

Date

Witness

If Individual is unable to sign this Authorization, please provide power of attorney or other legally binding consent and proof of identification at time of signature.

¹ NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Practice Leader 336-954-1007.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Dean Internal Medicine
1409 Yanceyville St - Ste C - Greensboro NC 27405
Phone: 336-954-1007 Fax: 336-954-1183