PAIN CLINIC OF NORTH CAROLINA

Thank you for choosing our office. In order to serve you properly, we need the following information.
(PLEASE PRINT). All information will remain confidential.

PATIENT INFORMATION: Today's Date: _______ / ________ / 20___

Patient Name: ____ check one: ☐ Male ☐ Female

Social Security #: _________ - ________ - __________

DOB: ____ / ____ / ____ check one: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Address:____

City: ____ State: ____________________ Zip: ______________

Patient #: Home: _______________________________________ Cell: __________________________________

Insurance Name: ____Policy # _____________________________

Policyholder's Name (If not Patient): _______________________________________Relationship:_____________

DOB: _____ / _____ / _____ SSN: ____

Emergency Contact Name and # ____

How did you hear of us? ____

Primary Care Physician ____________________________________ Location: ____________________________

Pharmacy Choice _______________________________ Location / Number ___________________________

ALLERGIES: ____

❒NO ALLERGIES

I authorize treatment for myself/my child based on the information I have provided regarding my past/current medical conditions. I also authorize the release, based on HIPAA privacy Act, of any medical information concerning myself/my child healthcare, advice and treatment provided only for the purpose evaluating/administering claims for insurance benefits/or continuity of care. I hereby authorize payment of insurance directly to the Provider. I also acknowledge billing my insurance is not a guarantee of payment and I am responsible for any amount not covered by my insurance company. I also release information to my employer concerning Workers Compensation Injury. **Insurance deductibles and co-pays or Self Pay payments are due at the time of service.**

____ Date: _______ / ________ / 20__

Signature of Patient/Guardian

____ Date: _______ / ________ / 20___

Witness

Patient Name: ____________________________________

HEALTH HISTORY QUESTIONNAIRE

*(Please complete **ALL** information requested)*

PAST MEDICAL HISTORY: ❒NONE

❒	AIDS or HIV	❒	Diverticulitis	❒	Migraine Headaches
❒	Arthritis	❒	Emphysema	❒	Osteoporosis
❒	Asthma	❒	Heart Disease	❒	Kidney Disease
❒	Back Trouble	❒	Hepatitis	❒	Reflux
❒	Cancer	❒	High Blood Pressure	❒	Seizures
❒	Chicken Pox	❒	Kidney Disease	❒	Sexually Transmitted Infection
❒	Diabetes	❒	Liver Disease	❒	Stroke

Other: ____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES: ❒NONE

❒	Appendectomy	❒	Foot	❒	Lung
❒	Back	❒	Gall Bladder	❒	Neck
❒	Blood Vessel	❒	Hernia Repair	❒	Oral
❒	Bowel	❒	Hip	❒	Sinus/ Nasal
❒	Brain	❒	Hysterectomy	❒	Stomach
❒	Eye	❒	Joints; knee/ hand/ wrist/ ankle	❒	Thyroid
❒	Facial	❒	Kidney	❒	Tonsillectomy
❒ **OTHER:**					

Family History ❒NONE

❒ Arthritis	❒ Diverticulitis	❒ Kidney Disease	❒ Reflux
❒ Asthma	❒ Emphysema	❒ Liver Disease	❒ Sinus/ Allergies
❒ Cancer	❒ Heart Trouble	❒ Migraines	❒ Stroke
❒ Diabetes	❒ Hypertension	❒ Osteoporosis	❒ Ulcers

PLEASE LIST ALL CURRENT MEDICATIONS:

____

____

____

PAST SOCIAL HISTORY:

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Lives With: ❒ Alone ❒ w/ Spouse ❒ w/ Family ❒ Friend

Social History: Tobacco: ❒No ❒Yes ppd:____ years____ Recreational Drugs: ❒No ❒Yes list:____________
Alcohol: ❒No ❒Yes (circle one) rarely moderately daily

Work Status: ❒ Student ❒ Employed ❒ Unemployed ❒ Retired ❒ Disabled

Acknowledgement of Receipt

Patient Name: ______________________ Date:__________________________

Our Notice of Privacy Policy provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form below, you agree that you have had the opportunity to read our Notice of Privacy Policy for Pain Clinic of North Carolina. Copies of our Notice of Privacy Policy are posted in the clinic lobby. Printed copies are available upon request at the reception desk.
Your health information may consist of items such as diagnosis, treatments, labs, prescriptions and appointments.

____

Signature of Patient, Parent or Guardian

HIPAA

CONTACT INFORMATION
(Please mark one for each question)

May we call you at home phone?	❑ YES	❑ NO	Work?	❑ YES	❑ NO
May we call you on your cell phone?	❑ YES	❑ NO			
May we leave a message at home?	❑ YES	❑ NO	Cell?	❑ YES	❑ NO

May we discuss your health information with your:

Spouse?	❑ YES	(name) ______________	❑ NO
Parent?	❑ YES	(name) ______________	❑ NO
Other?	❑ YES	(name) ______________	(relationship)____________

I give permission to the staff of Pain Clinic of North Carolina to contact me via **email** with information related to my protected health information. I also give permission to the staff of Pain Clinic of North Carolina to contact me via **email** concerning any statements or balances owed on my account.
I hold harmless the providers and staff of Pain Clinic of North Carolina for any and all information that unauthorized entities may receive. I will notify Pain Clinic of North Carolina of any changes in my **email** address in order to facilitate receipt of important information. My **email** address is

____.

Please print