Eden Internal Medicine, PLLC
PATIENT INFORMATION

Date **Chart #**

Last Name **First Name**

DOB: Gender: M F Social Security # Marital Status: Married Single Widow Divorced

Race: African-American Asian Hispanic/Latino White Other:_____

Language: English Spanish Other:_____

Address: City State Zip

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

May we contact you at any of the above numbers? Yes _____ No _____

Email Address:

Employment: Address:

Referred by: Date of Last Physical: Religion:

Pharmacy: Is this visit due to workman's comp? Yes____ No____

Spouse Last Name **First Name** **Middle**

DOB: Gender: M F Social Security #

Address: City State Zip

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Employment: Address:

Person to Notify other than Spouse: **Relationship:**

Address: Phone #:

Insurance Coverages / Driver's License **(A Copy of your cards is requested)**

Please note if you do not have insurance, $100.00 is expected to be paid prior to your office visit.

Self - 1st Insurance: Policy #

2nd Insurance: Policy #

Spouse's Insurance: Policy #

Authorization To Pay Benefits to Physician: I hereby authorize payment to be paid directly to Eden Internal Medicine, PLLC for surgical and/or medical benefits that are provided either in the office and/or hospital.

Signature:

Authorization To Release Information: I hereby authorize Eden Internal Medicine, PLLC to release any information acquired in the course of my exam/treatment necessary to process insurance claims.

Signature:

Eden Internal Medicine, PLLC expects payment of copays, deductibles and other balances to be paid at time of service unless payment arrangements have been discussed with the office manager and/or collection personnel. The office participates with several of the manage care programs. The patient has the responsibility to provide the office with their and their spouse's insurance cards at the time of service. If this information is not provided at time of service and/or in the allotted time required by the insurance company for filing, the patient will be expected to pay for the office visit and any other charges incurred. I understand the responsibilities as a patient, providing Eden Internal Medicine, PLLC with my insurance cards. I also understand that I will be responsible for all copay, deductibles and balances.

Signature:

NOTICE OF PRIVACY PRACTICES SUMMARY
Eden Internal Medicine PLLC

405 Thompson Street
Eden, N.C. 27288
336-627-4896
Effective 041403

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT OUR PRIVACY OFFICER FOR A FULL COPY OF OUR PRIVACY NOTICE. PLEASE READ THIS NOTICE CAREFULLY.

Uses and Disclosures: Eden Internal Medicine, PLLC (hereafter referred to as EIM) is permitted by law to disclose PHI of each patient to provide treatment, to receive payment for that treatment and for performing healthcare operations. Disclosure of PHI for treatment purposes could be made to physicians and other healthcare providers. PHI may be disclosed to the government, or to other third party payers for the purpose of obtaining payment for services provided. EIM may also disclose your PHI to carry on normal healthcare operations such as scheduling, appointment reminders and quality assurance.
Required Authorizations: EIM will not disclose a patient's PHI for any purpose aside from treatment, payment and healthcare operations without the patient's authorization to disclose the said information. Upon request for such authorization, the patient has the right to refuse and/or revoke any disclosure of his/her PHI.
Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45CFR Parts 160 and 164 (the "Privacy Regulations"), EIM has adopted privacy policies regarding usage of a patient's PHI.
Additional Information: For additional information regarding EIM's privacy policy or for a full copy of this notice, please contact our Privacy Officer. EIM reserves the right to revise the Privacy Notice giving a new revised date.

PATIENT'S ACKNOWLEDGEMENT / CONSENT

I understand that as a part of my healthcare, EIM creates and maintains health records describing my health history. I understand that EIM may use this information as:

1. A basis for planning my care and treatment;
2. A means of communication with many health professionals who contribute to my care;
3. A means by which a third-party payor can verify that services billed were actually provided; and
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been given the opportunity to read EIM's Privacy Notice which provides a more complete description of information used and disclosed. I understand that I have the right to review the notice prior to signing this authorization. I understand that EIM reserves the right to change its notice and practices. If EIM changes the notice, I can obtain a revised copy by asking the Privacy Officer and/or an employee of EIM. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other operational activities. EIM is not required to agree to the restrictions requested. If EIM does agree to such restrictions, however, EIM must comply with such restrictions. I understand that I may revoke this authorization in writing, except to the extent that EIM has already taken action.

I hereby authorize EIM to the use and disclosure of my PHI for the purpose of treatment, payment, and healthcare operations.
I hereby authorize EIM to release my PHI to the following person(s):_____
_____
_____**(name and relationship). I understand I may revoke this authorization at any time.**

I do hereby consent to treatment and examination by my physician or other physicians of EIM to provide and perform such medical/surgical care, tests, procedures, drugs and other services that are considered necessary and beneficial for my health and well being. I am aware that I may request a chaperone if I deem necessary. I am aware I have the right to refuse a third party in the exam room. I am aware, I may revoke this decision at any time <u>in writing</u> to EIM. If I am a minor and/or unable to make medical decisions, I am aware that I must have the consent of my parents and/or legal guardian.

_____ _____
Signature of Patient and/or Legal Guardian Printed Name of Minor/Patient

_____ _____
DOB Date Chart Number

Eden Internal Medicine, PLLC
405 Thompson Street
Eden, NC 27288
336-627-4896

Please Read Our Payment Policy In Its Entirety Before You Sign

Thank you for choosing Eden Internal Medicine as your primary care provider.

1) **SELF PAY**: If you do not have Insurance, payment in full is due at the time of your visit.

2) **INSURANCE**: We participate with many insurance plans. You are responsible for providing an up-to-date card at each visit. Failure to provide the correct information may result in the full amount becoming your responsibility. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding coverage.

3) **COPAYMENTS**: All Co-payments and Co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.

4) **NON-COVERED SERVICE**: Please be aware that some services you receive may not be covered or considered medically necessary by Medicare or other insurers, this amount will therefore be your responsibility.

5) **CLAIM SUBMISSION**: We will submit your claims and assist getting your claims paid. However if your insurance company needs additional information, it is your responsibility to comply with their request. Failure to do so will make the total balance your responsibility.

Eden Internal Medicine is committed to providing quality healthcare to our patients. If you are unable to abide with our Payment Policy, please speak to either our billing department or office manager prior to your office visit.

I have read and understand the payment policy. I agree to abide by its guidelines. Failure to do so may cause your account to be turned over to collections. This will affect your credit rating for seven (7) years.

_____ _____
Signature of patient or responsible party Date

_____ _____
Print Name Chart #

MEDICAL HISTORY

Name

1. Family History

		If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters	(Circle Sex) M F				
	M F				
	M F				
	M F				
	M F				

2. Check if any *blood relative* has had any of the following and enter relationship.

	Yes	No	Relation		Yes	No	Relation		Yes	No	Relation
Stroke	☐	☐		Epilepsy	☐	☐		Heart Attack	☐	☐	
Cancer	☐	☐		Suicide	☐	☐		Stomach Ulcers	☐	☐	
Breast	☐	☐		Migraine	☐	☐		Kidney Disease	☐	☐	
Colon	☐	☐		Asthma	☐	☐		Nervous Breakdown	☐	☐	
Cervical	☐	☐		Emphysema	☐	☐		Diabetes	☐	☐	
Tuberculosis	☐	☐		Bleeding Tendency	☐	☐					

3. Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Emphysema	☐	☐	Gallbladder Disease	☐	☐
Angina Pectoris	☐	☐	Gout	☐	☐	Diabetes	☐	☐	Jaundice	☐	☐
Heart Attack	☐	☐	Hay Fever	☐	☐	Cancer	☐	☐	Hepatitis	☐	☐
Other Heart Disease	☐	☐	Asthma	☐	☐	Nervous Breakdown	☐	☐	Colitis	☐	☐
High Blood Pressure	☐	☐	Frequent Lung Infections	☐	☐	Thyroid Disease	☐	☐	Arthritis	☐	☐
Anemia	☐	☐				Stomach Ulcers	☐	☐	Migraine Headache	☐	☐

4. Occupational

	Yes	No
Are you presently employed?	☐	☐
Does your work involve unusual work, exposure to dust, noise, radioactivity, etc.? (State below)	☐	☐
Do you have more than one job?	☐	☐
Do you work more than 60 hours a week?	☐	☐
Are you unable to perform any work because of disability?	☐	☐
Are you retired?	☐	☐
Have you ever worked with or been exposed to asbestos?	☐	☐

What is the name of your present occupation?

6. Habits

1. Check if you regularly smoke:
   ☐ cigarettes ☐ pipe ☐ cigars
   number per day_____ years _____
2. Do you drink beer, wine or liquor?
   ☐ never ☐ occ. ☐ regularly
3. Do you have difficulty sleeping?
   ☐ never ☐ often ☐ rarely
4. Do you awaken early in the morning and find it difficult to fall asleep again?
   ☐ never ☐ occ. ☐ often

5. Check which of the following, if any, you are regularly taking.

- ☐ Asprin; Bufferin, Anacin, Tylenol or similar products
- ☐ Cough medicine
- ☐ Hormones or birth control pills.
- ☐ Iron or poor-blood medications
- ☐ Laxatives
- ☐ Sleeping pills or tranquilizers
- ☐ Stomach or digestive medicine
- ☐ Vitamins
- ☐ Other Drugs

7. Family/Social

	Yes	No
Are you presently married?	☐	☐
Has there been a recent change in your marital status?	☐	☐
Do you have any sex problems?	☐	☐
Do you have any serious problems with your children?	☐	☐
Have there been any deaths in your family or among close friends in the past year or two?	☐	☐
Does anyone in your family have a serious illness or disability?	☐	☐
Were you in the military service?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Have you ever been treated for a drinking problem?	☐	☐

Allergies (Medication/Other): _____

Remarks: _____

Interim Review of System

Name _____ Date _____ Chart # _____

Current List of Medications and Dosage

List of Hospitalizations / Surgeries / Reason

Last Tetanus Shot _____

Last Pneumovax Shot _____

Known Medical Problems _____

ONLY CHECK THE BLANKS IF THE ANSWER IS "YES"

General
Weight Loss/Gain _____
Fatigue _____
Fever _____

Skin
New Lesions _____
Itching _____
Rash _____

HEENT
Blurry Vision _____
Double Vision _____
Eye Pain _____
Visual Loss _____
Decreased Hearing _____
Earache _____
Ringing in Ears _____
Frequent Colds _____
Nasal Secretions _____
Hoarseness _____
Sore Throat _____
Voice Changes _____

Neck
Neck Mass _____
Neck Pain / Stiffness _____
Swollen Glands _____

Respiratory
Cough _____
Shortness of Breath _____
Spitting Up Blood _____
Sputum Production _____
Wheezing _____

Breast
Breast Mass _____
Breast Pain _____
Nipple Discharge _____
Skin Changes _____

Cardiovascular
Irregular Heart Rate _____
Chest Pains _____
Edema _____

Cardiovascular (continued)
Difficulty Breathing _____
Palpitations _____
Shortness of Breath When Lying Down _____
Shortness of Breath _____

Gastrointestinal
Heartburn _____
Black Bowel Movements _____
Abdominal Mass _____
Abdominal Pain _____
Change in Bowel Habits _____
Constipation _____
Diarrhea _____
Difficulty Swallowing _____
Mucous in Stool _____
Vomiting up Blood _____
Nausea _____
Rectal Bleeding _____
Vomiting _____

Female Genitourinary
Frequency _____
Blood in Urine _____
Hesitancy _____
Incontinence _____
Pelvic Pain _____
Urgency _____
Urinary Retention _____
Voiding frequently at night _____
Change in Urinary Stream _____
Vaginal Bleeding _____
Vaginal Discharge _____

Male Genitourinary
Frequency _____
Blood in Urine _____
Hesitancy _____
Incontinence _____
Testicular Mass _____
Urethral Discharge _____
Urethral Discharge _____
Urinary Retention _____
Voiding frequently at night _____
Change in Urinary Stream _____

Neurological
Numbness, burning in Feet _____
Decreased Memory _____
Focal Neurological Symptoms _____
Headaches _____
Loss of Consciousness _____
Syncope _____
Tremor _____
Vertigo _____
Weakness _____
Dizziness _____

Musculoskeletal
Backache _____
Decreased Range of Motion _____
Joint Pain _____
Joint Swelling _____
Joint Stiffness _____
Muscle Weakness _____
Muscle Pain _____
Muscle Cramps _____

Psychiatric
Loss of Initiative _____
Frequent Crying _____
Feeling of Sadness _____
Insomnia _____
Early Awakening _____
Sleep more than 8 hours _____
Inability to Concentrate _____

Endocrine
Excessive thirst _____
Excessive urination _____

Hematology
Easy Bruising _____
Spontaneous Bleeding _____

Other
Smoking Habits # Packs per day _____
Caffeine Use # Cups per day _____
Use of Alcohol Yes No
Recreational Drug Use Yes No
Sexually Transmitted Disease Past/Present Yes No