

THANK YOU FOR BEING A PART OF *MASONBORO FAMILY MEDICINE, P.C.*  
WE'RE GLAD YOU ARE HERE!

PATIENT INFORMATION SHEET

PLEASE COMPLETE ALL SECTIONS

Name \_\_\_\_\_  
(PATIENT'S FIRST NAME) (MIDDLE INITIAL) (LAST NAME) (NICKNAME)

M  F \_\_\_\_\_  
MARRIED \_\_\_\_\_ (DATE OF BIRTH) \_\_\_\_\_ WIDOWED \_\_\_\_\_ (SOCIAL SECURITY NUMBER) \_\_\_\_\_  
SINGLE \_\_\_\_\_ DIVORCED \_\_\_\_\_

Name \_\_\_\_\_  
(RESPONSIBLE PARTY'S FIRST NAME) (LAST NAME) (MIDDLE INITIAL)

Address \_\_\_\_\_  
(STREET ADDRESS) (PO BOX) (CITY/STATE/ZIP CODE)

Telephone \_\_\_\_\_  
(HOME) (WORK) (CELL)

Employer \_\_\_\_\_  
(EMPLOYER NAME) (OCCUPATION)

\_\_\_\_\_  
(STREET ADDRESS) (CITY/STATE/ZIP CODE)  Full Time  Part Time  Retired  Student

In case of emergency call: \_\_\_\_\_  
(NAME) (DAY TIME TELEPHONE)

\_\_\_\_\_  
(NAME) (DAY TIME TELEPHONE)

**\*\*Primary Insurance Information** \_\_\_\_\_  
(NAME OF INSURANCE COMPANY)

Mailing Address \_\_\_\_\_  
(STREET/PO BOX) (CITY/STATE/ZIP CODE)

\_\_\_\_\_  
(SUBSCRIBER/POLICY HOLDER) (DATE OF BIRTH)  SPOUSE  CHILD  \_\_\_\_\_  
(RELATIONSHIP TO PATIENT)

**\*\*Secondary Insurance Information** \_\_\_\_\_  
(NAME OF INSURANCE COMPANY)

Mailing Address \_\_\_\_\_  
(STREET/PO BOX) (CITY/STATE/ZIP CODE)

\_\_\_\_\_  
(SUBSCRIBER/POLICY HOLDER) (DATE OF BIRTH)  SPOUSE  CHILD  \_\_\_\_\_  
(RELATIONSHIP TO PATIENT)

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliance resolutions. I authorize payment directly to MASONBORO FAMILY MEDICINE, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I understand that while MASONBORO FAMILY MEDICINE, P.C. will make every effort to notify me that a service may not be covered by my insurance, I agree that I will be financially responsible for any services considered not covered by my insurance. A photocopy of this authorization shall be considered as effective and as valid as the original.

May we leave normal lab results on your answering machine/ voice mail? YES / NO

Besides yourself, who may we discuss your medical information (including lab & x-ray results) billing information?

\_\_\_\_\_  
(NAME) (TELEPHONE) (NAME) (TELEPHONE)

\_\_\_\_\_  
(PATIENT OR RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP TO PATIENT)

\_\_\_\_\_  
(DATE) ( \*\*WE REQUIRE A COPY OF YOUR INSURANCE CARD TO FILE YOUR INSURANCE)

Patient Name \_\_\_\_\_ Today's date \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

What is your reason for this visit? \_\_\_\_\_

**SYMPTOMS** Mark the symptoms you *currently have or have had* in the past month

**GENERAL**

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Sweats
- Change in libido
- Fatigue

**GASTROINTESTINAL**

- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Dark tarry stools
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_

**OCCUPATIONAL**

- Check if you are exposed to:  Stress  Hazardous Substances  
 Heavy Lifting  Other
- Occupation: \_\_\_\_\_

**HEALTH HABITS** check which substances you use and describe how much you use (including past use)

Caffeine \_\_\_\_\_  Drugs \_\_\_\_\_  
 Tobacco \_\_\_\_\_  Alcohol \_\_\_\_\_

**PHYSICIAN NOTES** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EYE, EAR, NOSE, THROAT**

- Bleeding gums
- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Ringing in ears
- Sinus problems
- Vision (flashes or halos)

**HEART/ LUNGS**

- Shortness of breath
- Wheezing  Chest pain
- Palpitations  Poor circulation
- Productive cough
- Persistent cough
- Low blood pressure
- Swelling of the ankles

**GENITOURINARY**

- Blood in urine
- Frequent urination (day or night)
- Lack of bladder control
- Painful urination
- Difficulty starting to urinate
- Poor bladder emptying

**MUCLE/JOINT/BONE**

- Pain, weakness, or numbness in:
- Arms  Hips
  - Back  Legs
  - Feet  Neck
  - Hands  Shoulders

**SKIN**

- Bruise easily  Itching
- Hives  Rash
- Change in moles/freckles
- Sore that won't heal

**MEN ONLY**

- Breast lump
- Erection difficulties
- Hernia
- Lump in testicles
- Penis discharge
- Sore on penis

**WOMEN ONLY**

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other \_\_\_\_\_
- Last menstrual period: \_\_\_\_\_
- Last pap smear: \_\_\_\_\_
- Last mammogram: \_\_\_\_\_

**CONDITIONS** Mark the conditions that apply to you

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> HIV Positive         | <input type="checkbox"/> Prostate Problem    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Psychiatric Care    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Scarlet Fever       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Measles              | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Migraine Headache    | <input type="checkbox"/> Suicide Attempt     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Goiter         | <input type="checkbox"/> Miscarriage          | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Gonorrhea      | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gout           | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Vaginal Infections  |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Varicose Veins      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hernia         | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Cataracts          | <input type="checkbox"/> Herpes         | <input type="checkbox"/> Polio                | <input type="checkbox"/> High Blood Pressure |

**FAMILY HISTORY**

Relation	Age	State of Health	Age at Death	Cause of Death	Mark (x) if your blood relatives have any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Drug Addiction	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

**HOSPITALIZATIONS/SERIOUS ILLNESSES**

Year	Hospital	Description

**Have you ever had a blood transfusion?**

Yes  No

Approximate date: \_\_\_\_\_

**Social History:**

Single  Married

Divorced  Widowed

**PREGNANCIES**

Year of birth	Sex of child	Complications, if any

**Pharmacy you use:**

Phone: \_\_\_\_\_

Location: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge; I will not hold my physician or any members or his/her staff responsible for any errors or omissions that I may have made in completion of this form.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date

# MASONBORO FAMILY MEDICINE, P.C.

## Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

This notice describes how medical information about you may be released and disclosed and how you can access 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 and 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 your provider, 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 practice and 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. Or, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

**Payment:** Your protected health information may be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require relevant protected health information be disclosed to the health plan to obtain approval of the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging business activities. For example, we may disclose your protected health information to medical students that see patients in our office. Also, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate which provider you are seeing. We may also call you by name in the waiting area when the provider is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. They include: Public Health issues as required by law, Communicable Diseases; Health oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; 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 provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### *Your Rights*

**You have the right to inspect and receive a copy of 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 this 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 to not 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 and to whom you want the restriction to apply. **Your provider is not required to agree to a restriction that you may request.** If the provider 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 information 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 i.e. electronically.

**You may have the right to have your provider 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 deserve 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.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer, in person or by telephone at our main telephone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.



MASONBORO FAMILY MEDICINE, P.C.  
 6419-A CAROLINA BEACH ROAD  
 WILMINGTON, NORTH CAROLINA 28412  
 (910) 790-3660 Fax (910) 790-9499

REQUEST FOR RELEASE OF MEDICAL INFORMATION

To: \_\_\_\_\_  
 (PHYSICIAN/FACILITY NAME)

\_\_\_\_\_  
 (STREET/PO BOX ADDRESS) (CITY/STATE/ZIP CODE)

\_\_\_\_\_  
 (PHYSICIAN PHONE NUMBER AND/OR FAX NUMBER)

I, \_\_\_\_\_  
 (PRINT FULL NAME)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (DATE OF BIRTH)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (SOCIAL SECURITY NUMBER)

authorize and request that all medical records pertaining to my medical care be forwarded to:  
 Masonboro Family Medicine, P.C.  
 6419-A Carolina Beach Road  
 Wilmington, NC 28412

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This requestor should not redisclose my medical records to another party without further written consent. I understand and acknowledge this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (DATE) (SIGNATURE OF PATIENT)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (DATE) (SIGNATURE OF WITNESS)

*Andrew N. Illobre, PA-C    Kimberly J. Martin, PA-C    S. Grant Meyers, II, PA-C*

*Neill H. Musselwhite, III, MD*

*Dewey H. Bridger, III, MD*