

**Outpatient Information / Consent to Treat**

<b>PATIENT INFORMATION</b>		Account #:	Medical Record #:	Date:	
Patient Name:			Referring Doctor:		
Address:			Referring Doctor Phone #:		
City/State/Zip:			Primary Doctor:		
(H) Phone #:	(C)	Work Phone:	Employer/School:		
Social Security #:		Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:		Relationship:	(H) Phone #: (C)		
Responsible Party:		Relationship:	DOB:	SS#:	
Responsible Party Address:			City/State/Zip:	Phone #:	
<b>INSURANCE INFORMATION</b>					
Primary Insurance:		Employer:	Secondary Insurance:		Employer:
Insurance ID #:		Insurance Group #:	Insurance ID #:		Insurance Group #:
Insured Name:			Insured Name:		
Address:			Address:		
City/State/Zip:			City/State/Zip:		
Insured DOB:		Insured Social Security #:	Insured DOB:		Insured Social Security #:

**Financial Responsibility and Assignment of Insurance Benefits:**

I guarantee payment to Novant Health and its affiliates (Novant Health) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Novant Health for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

**Consent for Healthcare and Release of Medical Information:**

I voluntarily consent to healthcare treatment ("Treatment") from the physicians and staff at this Novant Facility. I consent to any necessary lab work, including HIV testing. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Would you like information on advance directives?  Yes  No

(Living Will, Health Care Power of Attorney, Advance Instruction for Mental Health Treatment, Organ Donation)

Signature of Patient or Authorized Person: _____	Date/Time _____
Insured Party or Financial Guarantor (if different from above): _____	Date/Time _____

**Acknowledgement of Receipt of Joint Notice of Privacy Practices:**

I have received a copy of the Novant Health Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on Novant Health's website at [www.novanthealth.org](http://www.novanthealth.org), by writing to the Privacy Officer, PO Box 33549, Charlotte NC 28233, or by requesting one at any Novant Health provider location.

Signature of Patient or Authorized Person: _____	Date/Time _____
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**For Staff Use Only**

Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.

Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer. **(Circle one)**

Signature of Staff: _____	Date/Time _____
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If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted \_\_\_\_\_  Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

SEX \_\_\_\_\_

S.M.W.D. \_\_\_\_\_

ADDRESS \_\_\_\_\_

TEL. NO. \_\_\_\_\_

INSURANCE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

OCCUPATION \_\_\_\_\_

**INSTRUCTIONS:** PUT IN THOSE BOXES APPLICABLE TO YOU AND IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED, WRITE IN YOUR ANSWER.**FAMILY HISTORY**

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN								
			1	2	3	4	1	2	3	4		1	2	3	4	5	6			
AGE (IF LIVING)																				
HEALTH (G) GOOD (B) BAD																				
CANCER																				
TUBERCULOSIS																				
DIABETES																				
HEART TROUBLE																				
HIGH BLOOD PRESSURE																				
STROKE																				
EPILEPSY																				
NERVOUS BREAKDOWN																				
ASTHMA, HIVES, HAY FEVER																				
BLOOD DISEASE																				
AGE (AT DEATH)																				
CAUSE OF DEATH																				

**PERSONAL HISTORY**

LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING ...	HAVE YOU EVER HAD ...	NO	YES	HAVE YOU EVER HAD ...	NO	YES
	<input type="checkbox"/> GONORRHEA <input type="checkbox"/> SYPHILIS			ANY <input type="checkbox"/> BROKEN <input type="checkbox"/> CRACKED BONES		
	ANEMIA			ARTHRITIS		
	JAUNDICE			HEART DISEASE		
	EPILEPSY			EVER BEEN KNOCKED UNCONSCIOUS		
	MIGRAINE HEADACHES			<input type="checkbox"/> FOOD <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DRUG POISONING		
	TUBERCULOSIS			EXPLAIN		
	DIABETES					
	CANCER					
	<input type="checkbox"/> HIGH <input type="checkbox"/> LOW BLOOD PRESSURE			ANY OTHER DISEASE		
	NERVOUS BREAKDOWN			EXPLAIN		
	<input type="checkbox"/> EMPHYSEMA					
	<input type="checkbox"/> HIVES <input type="checkbox"/> ECZEMA					
	<input type="checkbox"/> PNEUMONIA <input type="checkbox"/> PLEURISY			WEIGHT: NOW	ONE YR. AGO	
	FREQUENT <input type="checkbox"/> INFECTIONS <input type="checkbox"/> BOILS			MAXIMUM	WHEN	

**ALLERGIES**

ARE YOU ALLERGIC TO ...	NO	YES	ARE YOU ALLERGIC TO ...	NO	YES	ARE YOU ALLERGIC TO ...	NO	YES
<input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
<input type="checkbox"/> ASPRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE			EXPLAIN			EXPLAIN		
<input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS								
<input type="checkbox"/> TETANUS <input type="checkbox"/> ANTITOXIN <input type="checkbox"/> SERUMS			ADHESIVE TAPE			<input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS		

**SURGERY**

HAVE YOU HAD REMOVED ...	NO	YES	HAVE YOU HAD REMOVED ...	NO	YES	HAVE YOU ...	NO	YES
TONSILS			<input type="checkbox"/> OVARY <input type="checkbox"/> OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			HAD ANY OTHER OPERATIONS		
GALL BLADDER			EVER HAVE A TRANSFUSION			BEEN HOSPITALIZED FOR ANY ILLNESS		
UTERUS			<input type="checkbox"/> BLOOD <input type="checkbox"/> PLASMA			EXPLAIN		

**X-RAYS**

EVER HAVE X-RAYS OF ...	NO	YES	DATE	DISEASE PRESENT
CHEST				
<input type="checkbox"/> STOMACH <input type="checkbox"/> COLON				
GALL BLADDER				
EXTREMITIES				
BACK				
OTHER				

### SYSTEMS

DO YOU NOW HAVE OR HAVE YOU EVER HAD ...	NO	YES	DO YOU NOW HAVE OR HAVE YOU EVER HAD ...	NO	YES
ANY <input type="checkbox"/> EYE DISEASE <input type="checkbox"/> EYE INJURY <input type="checkbox"/> IMPAIRED SIGHT			KIDNEY <input type="checkbox"/> DISEASE <input type="checkbox"/> STONES		
ANY <input type="checkbox"/> EAR DISEASE <input type="checkbox"/> EAR INJURY <input type="checkbox"/> IMPAIRED HEARING			BLADDER DISEASE		
ANY TROUBLE WITH <input type="checkbox"/> NOSE <input type="checkbox"/> SINUSES <input type="checkbox"/> MOUTH <input type="checkbox"/> THROAT			BLOOD IN URINE		
FAINTING SPELLS			<input type="checkbox"/> ALBUMIN <input type="checkbox"/> SUGAR <input type="checkbox"/> PUS <input type="checkbox"/> ETC. IN URINE		
CONVULSIONS			DIFFICULTY IN URINATION		
PARALYSIS			NARROWED URINARY STREAM		
DIZZINESS			ABNORMAL THIRST		
HEADACHES: <input type="checkbox"/> FREQUENT <input type="checkbox"/> SEVERE			PROSTATE TROUBLE		
ENLARGED GLANDS			<input type="checkbox"/> STOMACH TROUBLE <input type="checkbox"/> ULCER		
THYROID: <input type="checkbox"/> OVERACTIVE <input type="checkbox"/> UNDERACTIVE <input type="checkbox"/> ENLARGED			<input type="checkbox"/> INDIGESTION <input type="checkbox"/> HEARTBURN		
ENLARGED GOITER			<input type="checkbox"/> GAS <input type="checkbox"/> BELCHING		
SKIN DISEASE			APPENDICITIS		
COUGH: <input type="checkbox"/> FREQUENT <input type="checkbox"/> CHRONIC			<input type="checkbox"/> LIVER DISEASE <input type="checkbox"/> GALL BLADDER DISEASE		
<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> ANGINA PECTORIS			<input type="checkbox"/> COLITIS <input type="checkbox"/> OTHER BOWEL DISEASE		
SPITTING UP BLOOD			<input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> RECTAL BLEEDING		
NIGHT SWEATS			BLACK TARRY STOOLS		
SHORTNESS OF BREATH <input type="checkbox"/> EXERTION <input type="checkbox"/> AT NIGHT			<input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA		
<input type="checkbox"/> PALPITATION <input type="checkbox"/> FLUTTERING HEART			CRAMPS IN LEGS IF WALKING OR JOGGING		
SWELLING OF <input type="checkbox"/> HANDS <input type="checkbox"/> FEET <input type="checkbox"/> ANKLES			<input type="checkbox"/> ANY CHANGE IN APPETITE <input type="checkbox"/> EATING HABITS		
HOW MANY PILLOWS DO YOU SLEEP ON AT NIGHT?			<input type="checkbox"/> ANY CHANGE IN BOWEL ACTION <input type="checkbox"/> STOOLS		
EXTREME <input type="checkbox"/> TIREDNESS <input type="checkbox"/> WEAKNESS			EXPLAIN		

### IMMUNIZATION - EKG

HAVE YOU HAD ...	NO	YES	HAVE YOU HAD ...	NO	YES
SMALLPOX VACCINATION (WITHIN LAST 7 YEARS)			POLIO SHOTS (WITHIN LAST 2 YEARS)		
TETANUS SHOT (NOT ANTITOXIN)			AN ELECTROCARDIOGRAM		WHEN

### HABITS

HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM	NO	YES	DO YOU USE ...	NEVER	OCC.	FREQ.	DAILY
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			LAXATIVES				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK.			VITAMINS				
			TUMS OR ROLAIDS				
LIST SPORTS, RECREATION, HOBBIES			TRANQUILIZERS				
			SLEEPING PILLS, ETC.				
			ASPIRINS, ETC.				
			CORTISONE				
			ALCOHOLIC BEVERAGE				
			COFFEE ( CUPS PER DAY)				
			TOBACCO: <input type="checkbox"/> CIGARETTES ( PKS PER DAY)				
			<input type="checkbox"/> CIGARS <input type="checkbox"/> PIPE <input type="checkbox"/> CHEWING TOBACCO				
			<input type="checkbox"/> SNUFF				
			APPETITE DEPRESSANTS				
			THYROID MEDICATION: <input type="checkbox"/> NO <input type="checkbox"/> YES, IN PAST <input type="checkbox"/> NONE NOW				
			HAVE YOU EVER TAKEN ...				
			<input type="checkbox"/> INSULIN <input type="checkbox"/> TABLETS FOR DIABETES <input type="checkbox"/> HORMONE SHOTS <input type="checkbox"/> TABLETS <input type="checkbox"/> NO				

### WOMEN ONLY

MENSTRUAL HISTORY ...	NO	YES	ARE YOU REGULAR: <input type="checkbox"/> HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT	NO	YES
AGE AT ONSET			DO YOU HAVE <input type="checkbox"/> TENSION <input type="checkbox"/> DEPRESSION BEFORE PERIOD		
USUAL DURATION OF PERIOD      DAYS			DO YOU HAVE <input type="checkbox"/> CRAMPS <input type="checkbox"/> PAIN WITH PERIOD		
CYCLE (START TO START)      DAYS			DO YOU HAVE HOT FLASHES		
DATE OF LAST PERIOD					
PREGNANCIES	NO	YES		NO	YES
CHILDREN BORN ALIVE (HOW MANY )			STILL BORN (HOW MANY )		
CESAREAN SECTIONS (HOW MANY )			MISCARRIAGES (HOW MANY )		
PREMATURES (HOW MANY )			ANY COMPLICATIONS		