Medics Primary &
Urgent Care PC

504 Owen Drive Fayetteville, NC 28304 TEL: 910-221-3030 FAX: 910-221-3039

PERSONAL INFORMATION: DATE: _____

Name: _____ DOB: _____

SSN: _____ Email: _____

Sex: Male Female

Telephone: _____ Alt phone: _____

Race (circle one): American Indian Asian Pacific Islander Black White Hispanic Other

Address: _____ City: _____

State: _____ Zip code: _____

Preferred pharmacy: _____ Location: _____

Pharmacy Address: _____

Emergency Contact: _____ Relationship: _____

Telephone: _____

PLEASE INTIAL NEXT TO EACH STATEMENT

_____ I Hereby assign my insurance benefit to Medics Primary & Urgent Care, P.C

_____ I understand that I am financially responsible for all non-covered services.

_____ I authorize the provider to release all information required to process my claims.

_____ I have been offered the notice of Privacy Policy.

_____ I authorize the provider to receive my medication history.

In case of an emergency, do you give the permission to resuscitate you? YES NO

Signature: _____ Date: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

MEDICAL HISTORY

Patient Name:_____ **Date:**_____

List all Surgeries and approximate date: _____, _____,

_____, _____,
_____,

_____, _____,
_____,

_____, _____,
_____.

Medication/Food Allergies:

_____.

Current Medications: _____, _____, _____,

_____, _____, _____,

_____, _____, _____,

_____, _____, _____,

_____, _____, _____.

Tobacco Use: Yes No. what type? _____ **How often?**_____ **How long?**_____

Alcohol use: Yes No what type?_____ **How often?**_____ **How long?**_____

Ellicit drug use: Yes No What type?_____

Medics Primary &
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Donald Asante, MD **Frederick Asare, MD**

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MEDICS PRIMARY & URGENT CARE PC
504 OWEN DRIVE FAYETTEVILLE, NC 28304
PHONE 910-221-3030 FAX 910-221-3039
DR FREDERICK ASARE & DR DONALD ASANTE

Patient Name: _____ **Date:**_____

PERSONAL AND FAMILY HISTORY

Please check the boxes for conditions which run in your family below:

If known, complete the following information about yourself and blood relatives.

1. Father: ____ Alive ____deceased (age of death) _____ cause_____
2. Mother: ____ Alive ____deceased (age of death) _____ cause_____
3. Cancer: Specify_____ Mother____ Father _____Self _____ other: _____
4. heart disease: Mother____ Father _____Self _____ other: _____
5. Diabetes: Mother____ Father _____Self _____ other: _____
6: Asthma: Mother____ Father _____Self _____ other: _____
7. Seizure disorder: Mother____ Father _____Self _____ other: _____
8. Stroke/TIA: Mother____ Father _____Self _____ other: _____
9. High Cholesterol: Mother____ Father _____Self _____ other: _____
10. Hypertension: Mother____ Father _____Self _____ other: _____
11. Anemia: Mother____ Father _____Self _____ other: _____
12. Liver disease: Mother____ Father _____Self _____ other: _____
13. Anxiety: Mother____ Father _____Self _____ other: _____
14. Depression: Mother____ Father _____Self _____ other: _____
15. Tuberculosis: Mother____ Father _____Self _____ other: _____
16. kidney disease: Mother____ Father _____Self _____ other: _____
17. Hearing or vision Impairment: Mother____ Father _____Self _____ other: _____
18.Heart Attack: Mother____ Father _____Self _____ other: _____
19.Alcohol or Drug Dependence: Mother____ Father _____Self _____ other: _____
20.Other: Mother____ Father _____Self _____ other: _____

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MEDICAL RELEASE FORM

Patient Name_____ **DOB** _____

SSN__XXX-XX-_____

****

Requested from

Facility _____

Address:_____ **City,State:**_____ **Zip code:**_____

Ph: _____ **Fx:**_____

Send information to:

Facility:_____ **{ } Mail { } Fax { }Secure email**

Address:_____ **City,State:**_____ **Zip code:**_____

Ph:_____ **Fx:** _____

Email:_____

I _____, **hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical records or a summary/ narrative of me protected health information to the physician/person/facility/entity provided above.**

_____ _____ _____

Printed Name **Signature** **Date**

HIPAA Privacy Authorization Form

******Authorization for use or Disclosure of Protected Health Information **********

(Required by the Health Insurance Portability and Accountability Act, 45C.F.R parts 160, 164)

I Authorize *Medics Primary & Urgent Care, PC* to use and disclose the protected health information described below to _____(Name of individual).

This authorization for release of information covers the periods of healthcare as checked below.

{ } From: _____ to _____ { } All past, present and future periods.

{ } I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug use).

*****OR*******

{ } I authorize the release of my complete health record with the exception of the following information.

[ ] Mental health record [ ] Communicable diseases (including HIV and AIDS)

[ ] Alcohol/ Drug abuse treatment [ ] Other(please specify) _____

This authorization may be used by the person aforementioned for medical treatment/ consultation, billing, or payments and to make or cancel appointments.

I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____ _____

Printed Name **Signature** **Date**

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NO CALL/ NO SHOW POLICY

A "No Show" is defined as a missed appointment in which the individual does not call to cancel or reschedule within 24 hours prior to the appointment time.

My signature below acknowledges that I understand that a $25 fee will be applied on my account for each missed/ non-cancelled appointment.

A pattern of repeated "No Shows" to appointments will result in no further appointments being able to be made on my account and possible dismissal from this medical practice.

_____

Printed Name

_____ _____

Signature Date