Denton Healthcare ~18539 S. NC HWY 109 Denton, NC 27239 (P) 336-859-5001 (F) 336-859-1952

Patient Information

____

Patient Last Name First Name Middle/Maiden Name

☐ Married ☐ Single ☐ Divorced ☐ Widow

____

Date of Birth Social Security Number ☐M ☐F

____

Street Address City State Zip

____

Home Phone Cell Phone Preferred: ☐ Home ☐ Cell

____

Spouse's Name Spouse's Phone Spouse's Date of Birth

____

Emergency Contact Relationship Home/Cell Number

Email Address ______________________________

Responsible Party Information (If Patient Is Under 18)

____

Last Name First Name Date Of Birth

____

Street Address City State NC Home/Cell Number

Relationship to Patient ______________________

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Preferred Pharmacy ___________________________

Denton Healthcare is authorized to release my protected health information to the entities named below:

____

Name Relationship Name Relationship
~~~~~~

Name:_____ **DOB:**_____

Insurance Company:

_____

Member ID #

_____

***Is there a preference for a provider?**

____ No Preference
____ Dr. Clifton Baker
____ Helen Blackburn, FNP
____ Ruth Smith, FNP

Reason for first visit?

___ To establish care
___Other_____

_____

_____

Acceptance of Financial Responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another at fault. Also, if there is a workplace injury and the Workers Compensation carrier denies payment, I understand that I am responsible for these charges.

Authorization to Release Information: I hereby authorize Denton Healthcare to release any information acquired in the course of my examination or treatment to my insurance company, Workers Compensation or their representative.

HIPPA Medical Information Protection: I hereby authorize Denton Healthcare to receive and disclose any personal health information for my healthcare needs. By signing this form, I authorize Denton Healthcare to use and disclose my protected health information in accordance with established HIPPA guidelines. I also acknowledge that a copy of this privacy practices are on display and have been made available to me if I so desire.

_____ _____

Date Signature (Patient/Parent of Patient

Denton Healthcare 18539 S NC HWY 109 Denton, NC 27239
Phone: (336) 859-5001 Fax: (336) 859-1952

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Allergies

Allergy	Reaction

Medications

Medication Name and Dosage	Directions for use

Past Surgeries

Surgery	Date / Year

Name:_____ **DOB:**_____

Current or Past Medical Problems

☐ AIDS
☐Alcoholism
☐Anxiety
☐Asthma
☐Back Problems
☐Bleeding Disorder
☐Bronchitis
☐Cancer _____
☐Cataracts
☐Depression
☐Drug Dependency
☐Diabetes
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Goiter
☐Gout
☐Heart Attack
☐Heart Disease
☐Hepatitis A B C D
☐Hernia
☐High Blood Pressure
☐High Cholesterol
☐HIV Positive
☐Kidney Disease
☐Liver Disease
☐Mental Health Issues
☐Mononucleosis
☐Multiple Sclerosis
☐Neck Problems
☐Pacemaker
☐Pneumonia
☐Polio
☐Prostate Disease
☐Scarlet Fever
☐Stroke
☐Thyroid Disease
☐Tuberculosis
☐Ulcers

Family Medical History

Mom: ☐ Alive ☐ Deceased Medical Problems: _____

Dad: ☐ Alive ☐ Deceased Medical Problems:_____

Brother: ☐ Alive ☐ Deceased Medical Problems: _____

Sister: ☐ Alive ☐ Deceased Medical Problems: _____

Other Family Medical History_____

Social History

Do you Smoke or Vape? _____ If yes which one and how much per day? _____

Do you Dip or Chew? _____ If yes which one and how much per day? _____

Do you use any illegal drugs? _____ If yes what kind? _____

Do you Drink Alcohol? _____ If yes how much? _____

Do you eat healthy? _____

Do you exercise? _____ If yes how much? _____

Do you have a Smoker detector in your home? _____

Do you wear a seat belt in the car? _____

Are you Single, Married, Separated, Divorced, Widowed? _____

I have reviewed DHC's HIPAA statement.

We will protect your medical records and other personal health information in accordance to the US Federal Statute.

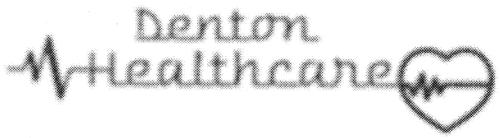
I give consent to DHC to retrieve and use my medication history from Sure Scripts.

I give consent to DHC to electronically query and retrieve my medical records for treatment purposes from all available sources.

I give DHC permission to use this in place of my electronic signature, and may initial on behalf of myself, and is valid as long as I am a patient.

Signature_____

Date_____



18539 S NC HWY 109
Denton, NC 27239
(P) 336-859-5001
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~~~~NO SHOW POLICY~~~~

If your schedule changes and you can not keep your appointment, please contact us so we may reschedule you, and accommodate those patients waiting for an appointment.

As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at a 24 hours' notice.

If you do not cancel or reschedule your appointment with us at least a 24 hours' notice, you will be assessed a **$25 "no-show"** service charge to your account. This charge is not reimbursable by your insurance company, and you will be billed directly for it.

After three consecutive "no shows" to your scheduled appointment, our practice may decide to terminate its relationship with you.

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If you are more 15 minutes late for your appointment, you will be asked to reschedule.

Payment is expected at time of service. All balances owed must be paid prior to next visit, or payment arrangements made before scheduling an appointment.

Date: _____

Signature: _____
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DENTON HEALTHCARE 18539 S NC HWY 109, DENTON, NC 27239 (P) 336-859-5001 (F) 336-859-1952

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: DENTON HEALTHCARE

Address: 18539 S NC HWY 109

City, State, Zip: DENTON, NC 27239

☐ **Please mail records.**
☐ **Please fax records.**

Fax: 336-859-1952 **Phone:** 336-859-5001

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative