WAKE HEALTH
MEDICAL GROUP

Patient Registration Information: (Please print clearly)

All bold areas must be completed by adult (18+) or legal guardian (for minors)

Legal Name:_____
First Last M.I.

Nickname? _____ **Date of Birth**: _____ **Age**: _____ **Gender**: M F

Primary Address:_____ **City**:_____ **State**: ____ **Zip**:_____

Primary Phone :(___)_____Other: (___)_____ **Under 18?** Yes No

Occupation:_____ Social Security Number: _____

Email Address*(appointment confirmation, billing correspondence, advertising): _____@_____. _____
*may opt out of advertising emails via "unsubscribe" upon receipt of email.

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT- Name: _____ **Primary Phone:** _____

Relationship to patient: _____

Patient Doctor (Internist, Family Practitioner, Pediatrician): _____

Address:_____ **Phone:** (____)_____

Pharmacy Name & Phone Number:_____

How did you hear about us/Referred by? _____

FOR MINORS - Parent or Guardian Information

Name: _____ **Date of Birth:** _____ **SSN:** _____

Employer: _____ **Phone: (___)**_____

Employer's Address: _____

REASON FOR VISIT (*CIRCLE ONE*):

MEDICAL / COSMETIC

MEDICAL INSURANCE INFORMATION:

Name of Insurance Company: _____ **Type of plan**: _____

Member ID #:_____ **Group #:**_____ **RX Bin:** _____

Policy Holder's Name:_____ **Date of Birth:** _____

Relationship to Patient (circle one): **Parent/Spouse/Dependent** **SSN:** ____- ___-___

Employer:_____ **Phone**: (___)_____

NOTICE TO PATIENT: THIS PAGE MUST BE FULLY COMPLETED/SIGNED

Physician-Patient Arbitration Agreement (PPAA):

I acknowledge that I have seen and read the PPAA:_____ *Copy available upon request.*
Initials

I acknowledge that I understand and agree to have any issue of medical malpractice decided by natural arbitration and understand my patient rights under the Physician-Patient Arbitration Agreement: _____
Initials

_____Date: ___/___/___ Physician/Authorized Office Personnel: _____
Patient/Legal Guardian Signature

Authorization to Contact Patient and Record of Disclosures (HIPAA):

The **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (**check all that apply**):

___Okay to give detailed information via Voicemail, Email or Text
___Leave a message with office call back number only via Voicemail, Email or Text

___Other:_____

I authorize the release of protected health information to the individual(s) listed below:

Name:_____Phone: (___) _____ Relationship: _____

Name:_____Phone: (___) _____ Relationship: _____

I understand that I may revoke this authorization at any time by submitting a written request:

_____ _____
Patient/Guardian Signature **Printed Name of Patient/Guardian** **Date** ___/_____/____

I acknowledge that I have seen the Notice of Privacy Practices: _____ *Copy available upon request.*
Initial

I acknowledge that I have read and understand the Office Policies: _____ *Copy available upon request.*
Initial

Medical Information

I. Medical/Surgical History:

Do you have now or have you ever had:

	Yes	No
Thyroid Disease		
High Blood Pressure		
Diabetes/High Blood Sugar		
Asthma		
Tuberculosis		
Hayfever/Seasonal Allergies		
Seizures		
Stroke/Mini-Stroke		
Heart Attack/Angina		
Pacemaker		
Heart Murmur/Palpitations		
Kidney/Bladder Problems		
Prostate Problems		
Glaucoma		
Hepatitis/Liver Disease		
Recurrent Yeast Infections		
Bowel Disease/Colitis/Crohn's		
Frequent/Severe Headaches/Migraines		
Cancer (other than skin)		
Radiation		
Artificial Joint Heart Valve		
Past Surgery		
Other		

If YES to any above, please explain:

II. Current Health:

	Yes	No
Do you smoke?		

How much per day? _____

	Yes	No
Do you drink alcohol?		

How much? _____

	Yes	No
Do you use drugs?		

How much? _____

III. Medications

List all medications you are taking, including any over-the-counter herbals or vitamins:

IV. Dermatologic History:

Do you have now or have you ever had

	Yes	No
Keloids/Abnormal Scarring		
Poor Wound Healing		
Skin Pigmentation Problems		
Reaction To Local Anesthetics		
Cold Sores/Herpes Infections		
Eczema		
Psoriasis		
Abnormal ("Dysplastic") Moles		
Precancerous Spots		
Skin Cancer – Melanoma		
Skin Cancer – Basal Cell		
Skin Cancer – Squamous Cell		
Abnormal Cold Sensitivity		
Abnormal Sun Sensitivity		
Abnormal Sun Sensitivity		
Cosmetic Surgery		

If 'Yes' to any above, please explain:

V. Allergies:

Are you sensitive / allergic to any oral medications? Please List:

VI. Family History

Do you have a family history of:

	Yes	No
Allergies/Asthma		
Skin Cancer – Melanoma		
Abnormal ("Dysplastic") Moles		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		

VII. Females

	Yes	No
Excess Facial/Body Hair		
Irregular Menstrual Periods		

How many pregnancies? _____

How many miscarriages/abortions?		
Are you pregnant or nursing?		
Names/ages of your children:		

Assignment of Rights & Benefits (1)

Patient's Name (or responsible party for a minor)

I herby assign all rights and benefits under my contract with my insurance company to Wake Health Medical Group and/or Providers for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits Wake Health Medical Group and/or Providers to obtain from my insurance all information necessary, for the determination of benefits allowed under the contract and permits the direct disclosure to Wake Health Medical Group of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow Wake Health Medical Group and/or Providers to take actions necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to Wake Health Medical Group and/or Providers.

A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize Wake Health Medical Group and/or Providers to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

I also understand that my insurance policy is a contract between my insurance company and myself. If my insurance company does not pay a claim within 30 days after it is received, I agree to remit payment to Wake Health Medical Group and/or Providers within 2 weeks of receiving the bill. I agree to contact my insurance company regarding this settlement. Wake Health Medical Group and staff will assist me in processing my claim; however, I am ultimately responsible for payment of services rendered.

I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will within five days of receipt of this check make payment in the amount of said check to the physician or facility.

A $37.50 fee will be charged for each insufficient funds check returned.

This is a direct assignment of my rights and benefits under this policy.

_____	_____
Printed Name of Patient	**Printed name: (if other than patient)**
_____	_____
Patient/Guardian Signature	**Date**

(1) Assignment means "to give". This form means you are giving this office full authority to act on your behalf in obtaining insurance information and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments and amounts the insurance will not pay.