Wake Family Medicine
we care

1000 Darrington Dr. Suite 104 • Cary, NC 27513 • Phone (919) 380-1849 • Fax (919) 380-1851

Patient Information:

Name _____ Sex: M / F
First Middle Last (circle one)

Mailing Address: _____
Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____

E-mail Address: _____ Occupation: _____

Marital Status: Single / Married / Widowed / Divorced (Please circle one)

Emergency Contact: _____
Name & Relationship Phone Number

Insurance Information: (If you select **Self**, only fill out items marked with an *)

Relationship of patient to insured: ____ Self ____ Spouse _____Child ____ Other (Explain) _____

*Primary Insurance: _____

Policy Holder: _____
Name Phone Number

Date of Birth of Policy Holder: _____ SS# of Policy Holder: _____

*Policy Holders Employer: _____
Name Phone Number

*Secondary Insurance: _____

Secondary Policy Holder: _____
Name Phone Number

Date of Birth of Policy Holder: _____ SS# of Policy Holder: _____

*Policy Holders Employer: _____
Name Phone Number

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize Wake Family Medicine or my insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

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Financial Policy

We are committed to providing you with the best possible care. If you have Medical Insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, MasterCard, American Express, Discover or Visa. We will be happy to process your insurance claim as a courtesy to you. However, it is your responsibility to verify eligibility and benefits with your insurance company before being seen.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and appointments cancelled without 24 hours advance notice.

By signing below, you understand:

1. **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract**.
2. Our fees are generally considered to fall within the acceptable range by most companies. Therefore, our fees are covered up to the maximum range by most companies and up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of usual, customary, and reasonable (U.C.R) fees for this region. Most companies consider our fees usual, customary, and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services we render are considered a covered benefit in some contracts. Some insurance companies arbitrarily select certain services they will not cover for you. While we extend the courtesy of filing insurance claims to all of our patients, all charges are your responsibility from the date the services are rendered.

We must emphasize that as medical care providers, our relationship is with you, **not your insurance company.** While the filling of insurance claims is a courtesy that we extend to our patients**, all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, **please do not hesitate to ask us. We are here to help you.**

_____ _____

Signature Date

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Release of Medical Records

I give Wake Family Medicine and its staff permission to release information regarding my medical condition and treatment such as lab reports, test results, medications, diagnoses, prescriptions, medical records, etc. to the persons listed below
(Ex: Spouse, family member, friend, caregiver)

I understand that if I want to make any changes regarding release of my information, I must notify Wake Family Medicine and its staff in writing. I do not have to sign this authorization in order to receive treatment from Wake Family Medicine. The practice will not receive payment from a third party in exchange for using or disclosing protected health information.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian if Patient is a Minor Date

Due to privacy and confidentiality issues, permission is needed for the following: (please circle one)

- May leave **any message** (including lab reports, test results, etc.) on my **home** phone number answering machine Yes No
- May leave a message on my **home** phone number answering machine **only to state to call my doctors office** Yes No
- May leave **any message** (including lab reports, test results, etc.) on my **cell** phone number voice mail Yes No
- May leave a message on my **cell** phone voice mail **only to state to call my doctors office**
  Yes No
- May call me at my **work** number and leave any message (including lab reports, test results, etc.) Yes No
- May call me at my **work** only to state to call my doctors office Yes No
- May leave a message with my spouse, parent or significant other Yes No

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Patient History Form

Date: _____

Name: _____ **Height:** _____ **Weight:** _____ **Age:** _____

Present Illness: (Please describe in your own words your present problem.)

_____

_____

_____

Past Medical History: (Please indicate if you have – or have ever had – any of the following illnesses. Give details in the next section.)

☐ Anemia	☐ Kidney Disease	☐ Sinus problems	☐ Cancer
☐ Liver Disease	☐ Stroke	☐ Diabetes	☐ Meningitis
☐ Syphilis	☐ Heart Disease	☐ Polio	☐ Tuberculosis
☐ Hepatitis	☐ Rheumatic Fever	☐ Thyroid Disease	
☐ Seizure	☐ High Blood Pressure	☐ Other	

Serious Medical Illnesses: (Please list your past and present illnesses including the date and location you were treated.)

1. _____
2. _____
3. _____
4. _____

Serious Injuries: (Please list any serious injuries along with the date; including car accidents, broken bones, head trauma, etc.)

1. _____
2. _____
3. _____

Past Operations: (Please list type and date, hospital, and surgeon)

1. _____
2. _____
3. _____

Do you wear seat belts? ☐ Yes ☐ No

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Pregnancies ____ Miscarriages/ Abortions ____ Any complications? (If yes, please explain) _____

_____

List your children with age and sex:

_____

_____

__

Medications: (Please list all medications, including the strength and frequency. Please include any vitamins, hormones, birth control pills, and over-the-counter products.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you use tobacco products? ☐ Yes ☐ No If yes, what kind?

_____

If yes, for how many years and how much? _____

If you smoked in the past, when did you quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, what kind?

_____

If yes, how much and how often? _____

Allergies: (Please list medications to which you are allergic or ones you cannot tolerate for any reason.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Who in your family has had: (ex: Mother, Father, Brother, Sister, etc.)

1. Cancer (Please list what type) _____
2. Diabetes

   _____
3. High Blood Pressure _____
4. Heart Disease/ Heart Attack

   _____
5. Mental Disease

   _____
6. Migraine Headaches

   _____

7. Seizures/ Epilepsy _____
8. Stroke

   _____
9. Tuberculosis

   _____
10. Kidney Failure/ Dialysis _____
11. Brain aneurysm _____
12. Other _____

Have you ever had significant problems with any of the following? (Please circle all that apply)

Headaches	Muscle cramps	Suicidal ideas
Nausea	Muscle twitching/ jerking	Nervousness
Vomiting	Difficulty walking	Loss of appetite
Convulsions/ Seizures	Unsteady balance	Difficulty getting words out
Fainting	Loss of coordination	Hearing or seeing things
Loss of vision	Trembling/ Shaking	Heat intolerance
Droopy eyelids	Difficulty controlling bladder	Palpitations
Loss of smell	Difficulty controlling bowel	Chest pain
Loss of taste	Recent weight loss	Chronic cough/ cough blood
Ringing or buzzing in ears	Memory loss	Stomach pain
Dizziness	Confusion	Jaundice
Slurred speech	Depression	Swelling
Numbness/ Tingling	Anxiety/ Chronic worry	Constipation
Insomnia	Weakness	Penicillin allergy
Latex allergy	Anemia	Asthma