10 Page Drive, Pinehurst, North Carolina 28374 Phone: 910-295-6868 Fax: 910-295-1514

PATIENT INTAKE AND CONSENT FORM

First Name _____ MI ____
Last Name _____
Address _____
_____
City State Zip

Date of Birth ____/____/____ Today's Date___/_____/____
Age _____ Sex ☐M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W
Cell Phone (_____) _____ - _____
Home Phone (_____) _____ - _____
Work Phone (_____) _____ - _____

Responsible Party _____
Address _____
City _____ State _____ Zip _____
Phone Number _____
Patient Relationship to Responsible Party:
_____

Provide email to Join & use preferred method of contact!!!
Do you or a family member have a FollowMyHealth Patient Portal Login? ☐ Y ☐ N
Name of person requesting access_____
Relationship to patient

FollowMyHealth access info: **Please provide email address of the person requesting access to the portal:**
Email: _____@_____

Employer _____
Address _____
City _____ State _____ Zip _____

Occupation _____
Contact at Employer _____
Phone Number (_____)_____-_____

Referring Physician _____ **Primary Care Physician**: _____

Primary Insurance _____
Group # _____ ID # _____
Insured Employer _____
Relationship to Insured_____

Insured Name _____
Address _____City _____
State _____ Zip _____ Phone (_____) _____- _____
Insured Date of Birth ___/___/___ Insured Sex: Sex ☐M ☐ F

Secondary Insurance _____
Group # _____ ID # _____
Insured Employer _____
Relationship to Insured_____

Insured Name _____
Address _____City _____
State _____ Zip _____ Phone (_____) _____-_____
Insured Date of Birth ___/___/___ Insured Sex: Sex ☐M ☐ F

Emergency Contact Daytime Phone Number (_____) _____-

Initial Each Entry Below

CONSENT TO TREATMENT: I hereby consent to such treatment or equipment as prescribed by all physicians and technicians treating me. I understand that Pinehurst Neurology, PA will at all times exercise good faith in this relationship. This consent is intended as a waiver of liability for such treatment except acts of negligence. _____

TREATMENT OF MINORS/ADULTS: I, as a **parent/guardian/POA** of a patient receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I know and agree that Pinehurst Neurology is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Pinehurst Neurology, it's representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to receive or allow emergency and or medical services, including but not limited to ambulance, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Pinehurst Neurology and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. *I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment*. I agree that this authorization shall be valid until rescinded in writing or replaced by one of the later date. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian/POA Signature _____ Witness Signature _____

PINEHURST NEUROLOGY

SYSTEMS REVIEW

Patient's Name_____ D.O.B. _____

Do you have any of the following?

General			**Gastrointestinal**		
Weight Gain	No ☐	Yes ☐	Frequent Nausea Or Vomiting	No ☐	Yes ☐
Weight Loss	No ☐	Yes ☐	Difficulty Swallowing	No ☐	Yes ☐
Loud Snoring	No ☐	Yes ☐	Pain In Abdomen	No ☐	Yes ☐
Skin			**Musculoskeletal**		
Rashes, Hives, Eczema	No ☐	Yes ☐	Painful Or Swollen Joints	No ☐	Yes ☐
			Back Problems	No ☐	Yes ☐
Head-Eyes-Ears-Throat			Back Injury	No ☐	Yes ☐
Do You Wear Glasses	No ☐	Yes ☐			
Double Vision	No ☐	Yes ☐	**Hematologic**		
Poor Hearing	No ☐	Yes ☐	Slow To Heal After Cuts	No ☐	Yes ☐
			Anemia	No ☐	Yes ☐
Neck			Excessive Bruising	No ☐	Yes ☐
Stiffness	No ☐	Yes ☐			
Thyroid Trouble	No ☐	Yes ☐	**Endocrine**		
Enlarged Glands	No ☐	Yes ☐	Thyroid Disease	No ☐	Yes ☐
			Hormone Replacement	No ☐	Yes ☐
Breasts			Intolerance To Hot/Cold	No ☐	Yes ☐
Lumps	No ☐	Yes ☐			
Nipple Discharge	No ☐	Yes ☐	**Cardiovascular**		
			Shortness Of Breath W/Walking Or Lying Down	No ☐	Yes ☐
Respiratory			High Blood Pressure	No ☐	Yes ☐
Chronic Cough	No ☐	Yes ☐	Irregular Heartbeat	No ☐	Yes ☐
Asthma Or Wheezing	No ☐	Yes ☐			
Difficulty Breathing	No ☐	Yes ☐			
Psychiatric					
Depression	No ☐	Yes ☐			
Difficulty Sleeping	No ☐	Yes ☐			
Crying Spells	No ☐	Yes ☐			
Nervousness	No ☐	Yes ☐			

_____ _____

Physician's Signature Date

10 Page Drive, Pinehurst NC 28374
Phone: (910) 295-6868 / Fax: (910) 295-8780

PINEHURST NEUROLOGY

Authorization to Discuss Medical Information

Patient Name: _____ Patient Date of Birth: _____

Representative authorized to discuss/review information:
Name: _____
Address: _____
Phone: _____
Relationship to Patient: _____

Extent of Authorization (choose ONE):
A: ☐ Complete medical record including, but not limited to: appointments, medications, lab results, imaging study results, test results, plan of care. Includes records relating to: mental health, HIV/AIDS, alcohol/drug abuse).

B: ☐ Complete medical record with the exception of: mental health records, communicable disease information (HIV/AIDS), alcohol/drug abuse treatment, other: _____

Effective Period:
This Authorization will remain in effect until:
A: ☐ No Expiration Date
B: ☐ Expires _____ (specify expiration date or event)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)