Polyclinic Medical Center, Inc.

3030 Senna Drive, Matthews, NC 28105
Phone (704) 844-8971 Fax (704) 844-8972

PATIENT INFORMATION

Patient #:________________

Date_______/______/______

Name:____

Address:____
(Street) (City) (State) (Zip)

Phone:____________________ Social Security Number _______-______-________

DOB: _______/______/______ Race:______________________

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

EMAIL: ____

Employer's Name:__________________________________Phone:_______-__________-_________

Employer's Address: ____
(Street) (City) (State) (Zip)

Spouse's Name: ____

Spouse's Employer: ____________________________________Phone: _______-_________ -_________

Person to contact in case of emergency: ____

Relationship: ____Phone: ________- ________- _________

Insurance Information:

Insurance Name: _________________________________ Subscriber DOB: _______/_______/_________

Subscriber's Name: _______________________________ Social Security Number_______-______-_____

Subscriber's Employer's Name: _______________________Date Employed _______/________/________

Subscriber's Employer's Phone: ________-________-________

Subscriber's Relationship to Patient _______________________

Insurance Company Address: ____

Do you have additional insurance? ☐ Yes ☐ No
If "Yes" please complete the following

Insurance Company:____

Subscriber's Employer:___________________________Subsriber's Social Security Number_______-______-______

Subscriber's Employer's Phone:________-________-________ Subscriber's Relationship to Patient _______________

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105
Phone (704) 844-8971 Fax (704) 844-8972

Patient Name: ____

Age: ________________________________ SSN ________________________________

CONTACT LIST

Name: ____

Relationship: _________________________ Phone: ______________________________

Name: ____

Relationship: _________________________ Phone: ______________________________

You may contact me by:

Phone: ___________________ ☐Yes ☐ No Best time to call _________________

Leave message ☐ Yes ☐ No Leave Phone number only ☐ Yes ☐ No

Mail ☐ Yes ☐ No Fax: __________________ ☐ Yes ☐ No

PHARMACY

Pharmacy name: ____

Address: ____

Phone : ____

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105
Phone (704) 844-8971 Fax (704) 844-8972

MEDICAL HISTORY

Name:____Age_____________

- Headache
- Congestive heart failure
- Incontinence
- Hypertension
- Arrhythmia
- Asthma
- Gout
- Allergies/hay fever
- Shortness of breath
- Epilepsy
- Orthopnea
- Hyperlipidemia
- Fatigue
- Scarlet Fever
- Osteoporosis
- Diabetes
- Rheumatic Fever
- Prostate Disease
- Heart Palpitations
- Ulcer
- Liver Disease
- Heart Murmur
- GI disorder
- Anemia
- Chest pain, angina
- Lactose intolerance
- Arthritis
- Dizziness/fainting
- Renal disease
- Menstrual dysfunction
- Claudication
- GU disorder
- Anxiety
- Myocardial infarction
- Sexual Dysfunction
- Weight loss
- Bowel irregularity
- Strok/TIA
- Venereal disease
- Congenital Heart Disease
- COPD
- Endocrine disease

SOCIAL HISTORY/HABITS

- Smoke__________How long?__________
  Interested in stopping smoking?_________
- Exercise routine: _____________________
- Coffee: Cups daily ___________________
- Alcohol: amount______________________
- Illicit drugs
- Street Drugs: Type/amount______________

Diet:
- Salt Intake: ______________
- Fat Intake
- Contact with blood or body fluids at work? _______________________

Sleep:
- Difficulty falling asleep
- Early morning awaking
- Daytime drowsiness

PATIENT MEDICAL HISTORY

Name: ____Age_______________

Current Medications and dosages:
____
____
____
____

Drug Allergies:
____
____
____
____

Is there a history of: (Check column that applies)	Mother	Father	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY HISTORY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105
Phone (704) 844 8971 Fax (704) 844 8972

PATIENT INFORMATION DISCLOSURE

I…………………………….hereby authorize and consent Polyclinic Medical Center , Inc. (PMC) to disclose the following Personal Health Information (PHI), which include my name, billing information, SS #, address, PMC's providers progress notes and records to and for:

a) Other healthcare providers, consultants and staff for treatment related requirements.

b) Healthcare Management Organizations for billing and processing payments for my treatments.

c) Incidental use, which include sign-in sheets, discussion in the waiting room, PMC's healthcare staff in semi-private discussions.

I understand and acknowledge that excluding the above, my PHI will be held private and confidential within PMC. I also acknowledge that this authorization can be revoked with my written and signed notice. I have been given the right to have a copy of my PHI upon written and signed request and also to communicate any concerns about the privacy of my PHI.

Patient Signature: ______________________ Date: ______/_____/______

Exp. Date: ____/____/_____

Witness Signature: ______________________ Date: _______/_____/______

Print Name: ___________________________

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105
Phone (704) 844 8971 Fax (704) 844 8972

Please initial each line after reading

____ I understand that my co-pay is due at time of registration.

____ I understand that I have to present my insurance card at every visit.

____ I understand that if I am a Medicaid patient I must bring a signed current card every visit (Medicaid cards expires every 30 days).

____ I am responsible for all medical charges due to my insurance deductible no yet met and understand that payment is required at time of registration.

____ I understand that I am responsible for my 20% share of total costs, after my insurance deductible is met.

____ If I am a self pay patient a deposit will be required at time of registration:
$ 200.00 for new patients
$ 126.00 for follow up
$ 250.00 for physical
If my bill is more than my deposit, I must pay the difference before I leave.

____ I understand that a $25.00 processing fee will be added to all return checks.

____ I understand that each test and/or lab work carries an additional charge on top of the office visit cost and that I will be informed of all charges before any tests are performed. I understand that I am responsible for all charges incurred by authorizing the tests.

____ I understand that when signing a ABN if Medicare denies any charges I will be responsible for payment

____ I understand that Polyclinic will take my picture and keep it in its files for identification only, it will not be shared with anybody or used for marketing purposes.

____ Received copy and I understand and agree to the above statement

Patient Name:____

Signature ____

SSN _________________________________ Date ________/________/_______

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105
Phone (704) 844-8971 Fax (704) 844-8972

AUTHORIZATION TO TRANSFER HEALTH & PERSONAL INFORMATION

I____DOB_____/_____/____

Address____
(Street) (City) (State) (Zip)

Telephone___________________________hereby authorize:

Dr.____of

____

____to transfer by mail of fax

_____a) All my Health and Personal Information (HPI),
_____b) I understand that this is voluntary and treatment is not conditioned on signing
_____c) This authorization is valid for twelve months from the date of the signature.
_____d) I understand that I may revoke this authorization at anytime by notifying Polyclinic Medical Center, Inc. in writing.
_____e) I understand that Polyclinic Medical Center, Inc is not responsible for any third party outside this organization to maintain this information confidential.
_____f) all my laboratory and imaging reports and results, (LIRR)

From (date)______/____/______ to ______/____/______

To: Dr. ____________________________

Polyclinic Medical Center, Inc.
3030 Senna Drive, Matthews, NC 28105

and/or

____

____

____

____________________________________ _________/______/_______
Patient's signature

Polyclinic Medical Center, Inc
3030 Senna Drive, Matthews NC 28105
Phone (704) 844-8971 Fax (704) 844-8972

Patient name: ___________________________

SS nº: ____-____-____ DOB ____/____/____

Address: _______________________________

Telephone: (h) _____________ (w)__________

PERMISSIONS/ACKNOWLEDGEMENTS FOR TREATMENT

1. Permission for treatment: I hereby give permission to receive medical treatment and outpatient clinic care from the staff, nurse practitioner and physicians who are employed at the Medical Center. I understand that this permission is for general treatment only and my consent must be obtained prior to the performance of any special procedures.
2. Permission to release Personal Health information: I authorize Polyclinic Medical Center, Inc. and independent physicians or staff and other practitioners providing services by or in the Medical Center to release any medical information (including medical records which pertains to treatment for drug abuse or alcoholism) necessary to process insurance claims related to this outpatient care.
3. Assignment of Insurance Benefits and Third Party Claims: I/we hereby authorize payment directly to Polyclinic Medical Center, Inc. of clinic benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless the account is paid in full. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I also authorize payment of medical benefits otherwise payable to me for professional services performed by any physician on the active staff of Polyclinic Medical Center, Inc. I understand that I am financially responsible to the Medical Center and physicians for charges, whether or not covered by this agreement. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further agree that in the event the clinic benefits exceed charges of Polyclinic Medical Center, Inc. for its services in connection with this outpatient care, that or any of which I am responsible to the center on account of other treatments.
4. Medicare-Medicaid Patient Certification: Authorization to Release Information and Payment Request: I assign payment for the unpaid charges for certain outpatient physician services and by physicians for whom the center is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title IVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.
5. Personal Property Release: I acknowledge that any property, valuables, prostheses or other items which I have brought to the Medical Center are no responsibility of the Medical Center, and that I am responsible for any personal property which is lost or damaged unless I have placed this property in the control of the Medical Center staff.

_________________________/____/____
Signature of Patient Date

_________________________/_____/______
Signature of Witness Date

____
Signature of Surrogate, if Patient is Unable to Sign