Polyclinic Medical Center, Inc.
3030 Senna Drive
Matthews NC 28105
Phone (704) 844-9386 Fax (704) 849-9567

# PATIENT INFORMATION

Patient #: _____

Date _____/____/_____

Name: _____

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

Phone: _____ Social Security Number _____-_____-_____

DOB: _____/_____/_____ School: _____

**PARENT'S INFORMATION:**

Mother's Name: _____EMAIL _____

DOB: _____/_____/_____ Social Security Number _____-_____-_____

Employer: _____ Work Phone: _____

Father's Name: _____EMAIL_____

DOB: _____/_____/_____ Social Security Number _____-_____-_____

Employer: _____Work Phone: _____

**GUARDIAN'S INFORMATION:** (need proper documentation)

Name: _____

DOB: _____/_____/_____ Social Security Number _____-_____-_____

Employer: _____Work Phone: _____

EMERGENCY CONTACT:

Name: _____Relation to Patient: _____

Address: _____

Phone (H): _____ Phone (C) _____ Phone (W)_____

**INSURANCE INFORMATION:**

1st Insurance Name: _____Policy #_____Group # _____

Name of Insured: _____Relation to Patient: _____

2nd Insurance Name: _____Policy #_____Group #_____

Name of Insured: _____Relation to Patient: _____

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**Medical/Family History Questionnaire**

Patient Name_____ Date of Entry_____

Patient Number_____ Date of Birth_____

Address_____ Phone No_____

_____ Emergency No_____

Source of Information_____ Relationship_____

**Mother's Pregnancy/Child's Birth History**(under 2 yrs old)

| | | |
|---|---|---|
| Illness during pregnancy? | No | Yes |
| Any medications during pregnancy? | | No |
| Alcohol/Drug Abuse? | No | Yes |
| Problems at birth? | No | Yes |
| Describe:_____ | | |
| Type of delivery? Vaginal | C-Section | |
| Birth Weight_____ Discharge Weight_____ | | |
| Did baby receive Hepatitis B vaccine? | No | Yes |
| Date of Hepatitis B immunization:_____ | | |
| Name of Hospital_____ | | |
| Was first PKU done? | No | Yes |

_____

**Patient's Health History:** Has your child ever had….

| | | |
|---|---|---|
| Measles/Mumps/Chicken Pox? | No | Yes |
| Frequent ear infections? | No | Yes |
| Vision/Hearing Problems? | No | Yes |
| Skin Problems? | No | Yes |
| Asthma/Allergies? | No | Yes |
| TB/Lung Disease/Croup? | No | Yes |
| Seizures/Epilepsy? | No | Yes |
| High Blood Pressure? | No | Yes |
| Heart Defects/Disease? | No | Yes |
| Liver Disease/Hepatitis? | No | Yes |
| Diabetes? | No | Yes |
| Kidney Disease/Bladder Infections? | No | Yes |
| Handicaps/Disabilities? | No | Yes |
| Bleeding Disorders/Hemophilia? | No | Yes |
| Sexually Transmitted Diseases? | No | Yes |
| Emotional Problems/Suicide Attempts? | No | Yes |
| Hospitalizations/Surgeries? | No | Yes |
| Physical/Emotional Abuse/Broken bones? | No | Yes |

_____

**Social History:**

How many living in the household?_____
Who cares for the child?
Who lives in household?_____

School?_____
Grade?_____ Report Card?_____
School behavior problems?_____
Comments:_____
_

**Family History:** Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers, cousins, etc.) had

| Yes the following: | | | Who |
|---|---|---|---|
| TB/Lung Disease? | No | Yes | _____ |
| HIV/AIDS/ | No | Yes | _____ |
| Suicide Attempts? | No | Yes | _____ |
| Heart Disease? | No | Yes | _____ |
| High Blood Pressure | No | Yes | _____ |
| High Cholesterol? | No | Yes | _____ |
| Blood Disorders? | No | Yes | _____ |
| Diabetes? | No | Yes | _____ |
| Seizures? | No | Yes | _____ |
| Allergies/Asthma? | No | Yes | _____ |
| Mental Illness? | No | Yes | _____ |
| Mental Retardation? | No | Yes | _____ |
| Cancer? | No | Yes | _____ |
| Birth Defects? | No | Yes | _____ |
| Hearing/Speech Problems? | No | Yes | _____ |
| Kidney Disease? | No | Yes | _____ |
| Alcohol/Drug Abuse? | No | Yes | _____ |
| Stroke? | No | Yes | _____ |
| Hepatitis/Liver Disease? | No | Yes | _____ |
| Thyroid Disease? | No | Yes | _____ |
| Learning Problems | No | Yes | _____ |
| Attention Deficit Disorders | No | Yes | _____ |
| Family Violence? | No | Yes | _____ |

_____

**Adolescent History:** (interview separately)

Age at first period_____ LMP_____
Sexually Active? No Yes # of partners?_____
Sex of partners? M/F
Any fears of partner/other violence? No Yes
Smoker? No Yes Alcohol Use? No Yes
Drug Use? No Yes Working? No Yes
Do you think about hurting yourself No Yes
Access to gun/weapon? No Yes

**Provider:**_____
Date:_____

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# Parental Delegation Form
# Authorizing the Treatment of a Minor

I, _____, am the
Print Name

☐ Natural or adoptive parent of

☐ Guardian of

☐ Person who, under court order, is authorized to give consent for

the minor, _____.
Print name of minor

I, hereby, delegate_____
Print name of person to whom authority is delegated

to give consent to the treatment of the above named minor. The relationship of this person to the minor is

☐ A grandparent

☐ An adult brother or sister

☐ An adult aunt or uncle

☐ A stepparent

☐ Another adult who has care and control of the above named minor

_____ _____
Signature of Parent or Guardian Witness

_____ _____
Date Date

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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: _____

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# 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

_____

_____

_____

_____ _____/_____/_____
Signature Parent/Guardian Date

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**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 established patients
$ 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:_____

Parent/Guardian Signature _____

SSN _____ Date _____/_____/_____

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Patient # _____

Patient Name: _____

SSN _____-_____-_____DOB____/___/____

Address: _____

Phone (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 changes 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 IVII 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 of Medicaid claim. I request that payment of authorized benefits be made on my behalf.
5. Personal Property Release: I acknowledge that nay 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 Parent/guardian Date

_____
Signature of witness Date

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# PATIENT INFORMATION DISCLOSURE

I_____
(parent's/guardian's name)

hereby authorize and consent Polyclinic Medical Center, Inc. (PMC) to disclose the following Personal Health Information (PHI), which include name, billing information, SS#, address, PMCs 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 patient's treatments.

c) Marketing purposes which may or not benefit PMC and may be of benefit to me/patient and my/patient's treatment.

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

I understand and acknowledge that excluding the above, my/patient's 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/patient's PHI.

Patient's Name_____

Parent's /Guardian's Signature_____Date_____/____/_____

Exp. Date _____/_____/_____

Witness Signature _____Date_____/____/_____

Print Name _____

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# Preventive Screen Questionnaire

Patient Name:_____ DOB____/____/_____Patient #_____

| **Tuberculosis Risk Assessment:** (Initial visit and yearly thereafter) | Date ____ | Date ____ | Date ____ | Date ____ | Date ____ | Date ____ |
|---|---|---|---|---|---|---|
| 1. Was your child born in, or lived more than a year in a country other than the U.S.? Where?_____Year?_____ | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 2. Has your child been exposed to anyone with either active tuberculosis or a history of tuberculosis disease? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 3. Is your child currently living in a household with anyone who is HIV positive? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 4. Is your child part of a migrant worker family? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |

| **Lead Risk Assessment:** (6 months to 6 years) | Date ____ | Date ____ | Date ____ | Date ____ | Date ____ | Date ____ |
|---|---|---|---|---|---|---|
| 1. Does your child currently live, or has he/she ever lived in a house or apartment built before 1960 (includes day care center, preschool home, home of babysitter or relative)? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 2. Is anyone in the home being treated or followed for lead poisoning? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 3. Are there any current renovations or peeling paint in a home that your child regularly visits? | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 4. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.) | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |

Completed by/Date: _____ _____ _____ _____

_____ _____ _____ _____

Reviewed by/Date: _____ _____ _____ _____

_____ _____ _____ _____