PREMIER HEALTH CENTER

409 Wake Chapel Rd, Fuquay Varina, NC 27526

Phone: 919-567-9001 Fax: 919- 557-5540

Patient Information	**Responsible Party Information**
Name :	**Name:**
First Middle Last	First Middle Last
Date Of Birth: Sex**: M** ☐ **F** ☐	**Relationship :**
	Date Of Birth: Sex**: M** ☐ **F** ☐
Social Security #	Social Security #
Home Address:	Home Address:
City State Zip	City State Zip
Mailing Address:	
Home Phone : Message	Home Phone: Message
Employer name:	Employer name:
Address:	Address:
City State Zip	City: State Zip
Work Phone:	Work Phone:
Email Address(required):	Email Address:

PRIMARY INSURANCE ______________________ SECONDARY INSURANCE ______________________

PRIMARY INSURANCE ID ______________________ SECONDARY INSURANCE ID ______________________

Emergency Contact Person & Phone number ____

I certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process this claim for treatment, payment, or operations. I authorize payment of medical benefits to PHC provider or suppliers for services. I, the undersigned, hereby authorize the provider and whomever else he may designate as his assistant (s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is EXPECTED at the time of service. We will bill your insurance as a courtesy. I provide my consent for Premier Health Center in Fuquay-Varina, NC, to share relevant medical information with the North Carolina Immunization Registry and its partners.

Patient Signature ____ **Date** ____________

Responsible Party's Signature ______________________________________ **Date** ____________

Witness ____ **Date** ____________

PREMIER HEALTH CENTER

MEDICAL HISTORY FORM

NAME ____ **DATE OF BIRTH** ______________________________

A. **ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks.**

#	YES	NO	QUESTONS
1			Do you have a primary care physician? Name: ____________________ Date of last exam:___________
2			Do you have a dentist? Name: _______________________ Date of last exam:__________________
3			Have you been hospitalized or had a serious illness/injury in the last three years? Why : _____________
4			Do you have chronic pain? When? _____________________ Where? _________________________ How often or frequent ____
5			**CURRENT PRESCRIPTIONS** (Include vitamins, Herbs & supplements) ____
6			**ALLERGIES** ____

B. **DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWNG? (Check Yes or No)**

#	YES	NO	QUESTIONS	#	YES	NO	QUESTIONS
6			Allergies to medications	18			Allergies to food or other
7			Hepatitis	19			High blood pressure
8			Anemia	20			Kidney or bladder disease
9			Arthritis	21			Psychiatric illness
10			Asthma or Emphysema	22			Sexual disease: Chlamydia, Herpes, etc
11			Cancer, Where?	23			Skin disease or rashes
12			Diabetes or Gestational (pregnant) Diabetes	24			Stomach problems: gastritis, ulcer, other
13			Eye disease. Glaucoma. Cataract	25			Stroke
14			Ear. nose or throat problems	26			Thyroid, adrenal disease
15			Heart Disease or Pacemaker	27			Artificial joint

16			Surgeries (including sterilization)	**28**			Blood transfusions
17			Domestic abuse	**29**			Chemotherapy / Radiation

C:			WOMEN ONLY (Check Yes or No)				
#	YES	NO	QUESTIONS	#	YES	NO	QUESTIONS
			Are you pregnant or breast feeding?				When was your last PaP? ________________
			Are you taking birth control pills or shots?				Have You had an abnormal PaP?
			Do you have difficult periods?				When was your last mammogram?
			Have you had any miscarriages or abortions?				Have you had an abnormal mammogram?
			More than '1 sexual partner recently?				Have you had a hysterectomy? Full or Partial?
			Do you have pain with inter course?				At what age did you start your first period?

D:			HAVE YOU EXPERRENCED ANY OF THE FOLLOWLNG? (Check Yes or No)				
#	YES	NO	QUESTIONS	#	YES	NO	QUESTIONS
			Swollen ankles				Dry mouth
			Bleeding problems / bruising easily				Nausea and vomiting
			Chest pain (angina)				Rashes
			Cough: persistent or bloody				Seizures
			Diarrhea. constipation, blood in stools				Shortness of breath
			Dizziness				Sinus problems
			Fever				Difficulty swallowing
			Fainting				Excessive thirst
			Headache				Frequent or bloody urine
			Jaundice				Blurred vision
			Joint pain or stiffness				Recent weight gain or loss

E:			OTHER INFORMATION (Check Yes or No and fill in the blanks)
#	YES	NO	QUESTIONS
			Do you have any other diseases or medical conditions NOT listed on this form? lf so, please Explain:
			Please list any significant Family Medical History:
			Are you able to perform activities of daily living (ADL)? lf no, please explain:
			Do You have a religious, Cultural, physical, or other factors that might influence your care? lf so, please

F:			PLEASE LIST (Check Yes or No and fill in the blanks)				
#	YES	NO		#	YES	NO	
			Alcohol frequency______________________				Tobacco (smoke or chew) _______________
			Caffeine frequency ___________________				Recreational drug frequency _____________
			Date of Last Colonoscopy_________________				Date of Last Mamogram_______________________
			Date of Last Bone Density__________________________				Date of Last Prostrate Exam___________________________

Premier Health Center

Authorization for Release of Information

409 Wake Chapel Rd, Fuquay Varina, NC 27526

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PATIENT NAME ____ **DATE OF BIRTH** _________

STREET ADDRESS ______________ **CITY** ______________ **STATE** ________ **ZIP** ________

SSN ______________________ **PHONE NUMBER** ______________________

At the request of the individual above, I, Afaque Akhtar MD do hereby REQUEST/RELEASE

_ Discharge Summary _ Patholo8y Reports _ Emergency Reports

_ History & Physical _ _ Lab Reports - _ 2 years prior from the last date seen

_ Progress Notes _ Radiology Reports _

_ Operative _ _ ECG/EEG/Cardiac Cath

From the time period of ________________________ through ________________________

____**I DO**_____ **I DO NOT** Authorize the release of information related to AIDS (Acquired immunodeficiency syndrome) or HIV (Human immunodeficiency virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse

Purpose of Disclosure: _ Referral to specialist _ Insurance _ Workers comp. _ Change of Physician

_ Legal Investigation _ Disability Determination _ Personal _ Continuity of care

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect anv information released prior to the notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would no longer be produced by federal regulations.

Signature of Individual/Guardian ______________________________ **Date** ______________________

Witness ____ **Date** ______________________

Sent To ____ **Fax #:** ______________________

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Authorization / Consents

Financial Agreements and Authorizations for Treatment:

I hereby authorize Premier Health Center and its physicians and such assistants as a physician my designate to furnish and perform on or the Patients stated above ("Patient") such medical care. Examinations and treatment as may be ordered by a PHC physician in his or her medical Judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to PHC of all Medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of Services to be rendered by PHC to the Patient. l understand that to the extent permitted by applicable law, I am and l agree hereby to be, financially responsible to PHC for charges not covered by this agreement, and I hereby guarantee payment to PHC on demand for all such charges.

Initials: ____________

Authorization to Release Information:

I hereby authorize PHC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient‘s Examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with Which the Patient may have insurance coverage or may be assist in Payment of medical care provided by PHC to the patient. I also hereby authorize PHC t release any medical information to any licensed physician, health care provider, medical facility or designated pharmacy to which the patient may be referred, admitted or transferred for further medical care .I understand that may I revoke this authorization by written notice at any except to the extent that action already has been taken.

Initials: ____________

Consent to Obtain Medication Summary:

I hereby authorize PHC and its physicians and such assistants to obtain any previous physicians' offices, pharmacies, or database with such information to batter assist in my medical care.

Initials: ____________

HIPAA Acknowledgement:

I hereby acknowledge that I consent to PHC to use and disclosure of protected health information according to the Notice of Privacy Practices available to me at the front desk. I also understand that i have the right to revoke this consent any time by providing signed written request. However, I am aware that this revocation will not affect any previous disclosure already made in reliance on your prior consent.

Initials: ____________

Cancellation and No Show Policy:

I hereby acknowledge that I am aware of PHC office cancelation and no show policy .I will make an honest attempt to cancel or reschedule my office appointment at least 24 hours prior to my schedule appointment time.

Initials: ____________

I acknowledge that I have read and initialed all above consents to Premier Health Center

Patient Name: ____

Patient Signature: ____

Date: ____

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Allergy Questionnaire - Intake questions

Patient Name ______________________________ Date of Birth ____________

Reviewed by ______________________________ Date ________________

1-Do you experience any of these symptoms more than twice per year:

Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose sore throat, itchy irritated eyes. Sinus pain . Ear pain, unexplained fatigue skin irritation, snoring? ☐ YES ☐ NO

2-Have you ever been diagnosed with asthma or bronchitis? ☐ YES ☐ NO

3- Do you experience symptoms of allergies? ☐ YES ☐ NO

4- Regarding possible food allergies. Do you experience any of the following: (check all that apply?)

- ☐ Bloating after eating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Upset stomach
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Tingling of the mouth or any other unusual sensation

OPIOID RISK TOOL

Patient name: ___________________________________ Date: ____________________

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		**[ ]**		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

Patient Health Questionnaire (PHQ-9)

Patient name: ________________________________ Date: __________________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

TOTAL SCORE ______________