Wakefield Family Medicine

A New Meaning to Family Care

Octavian M. Belcea, MD
Family Physician

Medical Patient Registration

Patient's Name: _____
Last **First** **Middle**

Address: _____
Street **City/State** **Zip**

Home: _____ **Work**: _____ **Cell:** _____

Age: _____ **Birth Date:** _____ **Marital Status:** _____

Soc. Sec. Num.: _____ **Sex:** _____ **Race** (Optional)**:** _____

Employer: _____ **Occupation**: _____

Name of Spouse/Guardian: _____

Preferred Pharmacy: _____ **Phone #**: _____

Pharmacy Address: _____

Referred By: _____

Emergency Contact Information

Name: _____ **Phone:** _____

Required Information to Process Insurance Claims

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ **Policy Holder's SSN:** _____

I understand that I am financially responsible for all charges for my services, including any balance allowed after insurance payment. I authorize payment of medical benefits for myself or the name provided for professional services rendered. I authorize release of medical information necessary to process claims.

Signed: _____ **Date:** _____

I have received a copy of this office's Notice of Privacy Practices (patient may refuse to sign)**.**

Signed: _____ **Date:** _____

2810-115 Wakefield Pines Drive, Raleigh, NC 27614 • Phone (919) 488-0111 • Fax (919) 488-0104 • FamilyCare@WakefieldDoctors.com

Medical History Form

Name: _____ **Date of Birth**: _____ **Age**: _____ **Gender**: _____

Allergies (List all medication/health products with which you have had a reaction and what type of reaction occurred):

_____

_____

Medications (List all medication names including non-prescription medications, vitamins, herbs or supplements) Please include the dosage and how many you take daily:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Family History

	Father	Mother	Child	Bro/Sis	Grandprts		Father	Mother	Child	Bro/Sis	Grandprts
Alcohol	☐	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	Migraine	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	Stroke	☐	☐	☐	☐	☐
Epilepsy/Convulsion	☐	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐						
Heart Disease	☐	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐	☐

: _____

Surgeries:

_____

_____

Hospitalizations:

_____

_____

Immunizations (year of last):

Tetanus _____
Flu _____
Pneumonia _____
Other: _____

Tests (year of last):

Cholesterol _____
Tuberculosis _____
Other: _____

Patient Name _____

Please mark symptoms you've experienced in the past year, circle symptoms you're experiencing currently

CONSITUTIONAL:
☐Unexplained weight loss
☐Night sweats
☐Feeling tired
☐Change in appetite
☐Change in sleeping pattern
☐Fever
☐Recent trauma
☐Unexplained falls
☐Polydipsia (excess thirst)
☐Polyuria (high volume urine)
☐Cold intolerance
☐Heat intolerance

EYES:
☐Visual changes
☐Headache
☐Eye pain
☐Double vision
☐Blind spots
☐Floaters
☐Feeling like a curtain got pulled down
☐Conjunctivitis (pink eye)
☐Last eye check: _____

ENT:
☐Runny nose
☐Nose bleeds
☐Sinus pain
☐Stuffy ears
☐Ear pain
☐Ringing in ears
☐Gingival (gum) bleeding
☐Toothache
☐Sore throat
☐Pain with swallowing
☐Last dental visit: _____

CARDIOVASCULAR:
☐Chest pain
☐Shortness of breath
☐Exercise intolerance
☐Shortness of breath when when lying down
☐Swelling
☐Palpitations
☐Feeling faint
☐Loss of consciousness
☐Calf pain with walking or running

RESPIRATORY:
☐ Cough
☐Sputum
☐Wheeze
☐Hemoptysis (coughing blood)
☐Shortness of breath
☐Exercise intolerance

GI:
☐Abdominal pain
☐Difficulty swallowing solids
☐Difficulty swallowing liquids
☐Indigestion
☐Bloating
☐Cramping
☐Loss of appetite
☐Avoiding certain foods
☐Nausea
☐Vomiting blood
☐Diarrhea
☐Constipation
☐Inability to pass gas
☐Bright red blood per rectum
☐Foul smelling stool
☐Dark stools
☐Last colonoscopy: _____
☐Fecal incontinence

URINARY:
☐Irritation
☐Difficulty urinating
☐Incontinence
☐Dysuria (painful urination)
☐Hematuria (blood in urine)
☐Nocturia (waking at night to urinate)
☐Polyuria (high volume urine)
☐Terminal dribbling
☐Decreased force of stream

GENITAL:
☐Erectile dysfunction
☐Testicular pain
☐Penile pain
☐Testicular enlargement
☐Decreased libido

MUSCULOSKELETAL:
☐Muscle pain
☐Joint pain
☐Bone pain
☐Joint misalignment
☐Joint stiffness
☐Joint swelling
☐Decreased range of motion
☐Noise in joint
☐Functional deficit

SKIN:
☐Itching
☐Rashes
☐Stretch marks
☐Lesions
☐Wounds
☐Incisions
☐Dark line in the back of the neck
☐Nodules
☐Tumors
☐Eczema
☐Dryness
☐Discoloration
☐Hair loss
☐Skin darkening in non exposure areas
☐Easy bruising
☐Excessive bleeding
☐Last dermatology check:

BREAST:
☐Pain
☐Soreness
☐Lumps
☐Discharge

NEURO:
☐Seizures
☐Fainting
☐Fits
☐Headache
☐Pins and needles
☐Numbness
☐Limb weakness
☐Poor balance
☐Speech problems
☐Urinary sphincter weakness
☐Fecal sphincter weakness
☐Higher mental function symptoms
☐Deficits in special senses such as sight, smell, hearing and taste
☐Auditory hallucinations
☐Visual hallucinations

PSYCH:
☐Depression
☐Change in sleep patterns
☐Anxiety
☐Difficulty concentrating
☐Body image issues
☐Poor work or school performance
☐Difficulty with relationships
☐Paranoia
☐Lack of motivation
☐Lack of energy
☐Episodes of mania
☐Episodic change in personality
☐Expansive personality
☐Sexual binges
☐Financial binges

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(P)4919-488-0111 (F)919-488-0104

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Very Important-Please fax records regardless of how many pages

I AUTHORIZE: (Choose ONE)

Wakefield Family Medicine 2810-115 Wakefield Pines Drive Raleigh, NC 27614 Phone: 919.488.0111 FAX: 919.488.0104	OR	Name: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

TO RELEASE TO: (Choose ONE)

Wakefield Family Medicine 2810-115 Wakefield Pines Drive Raleigh, NC 27614 Phone: 919.488.0111 FAX: 919.488.0104	OR	Name: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

THE MEDICAL RECORD OF:

Name: _____ Date of Birth: _____

Address: _____ SSN: _____

_____

City: _____ State: _____ Zip: _____ Phone: _____

Treatment Dates: From: _____ to _____ OR **ALL**

Information to be released (Check information required):

☐ Clinical Notes	☐ Progress Notes	☐ Nurse Notes	☐ X-Ray Reports
☐ Emergency Room	☐ Operative Reports	☐ Discharge Summary	☐ Doctor Consults
☐ Urgent Care	☐ Pathology Reports	☐ Lab Reports	☐ Other_____
☐ History & Physical	☐ Physician Orders	☐ EKG, EEG, EMG	☐ _____

I acknowledge that the data to be released MAY INCLUDE material that is protected by law. My ***initials*** in the boxes below authorize the release (if applicable) of information pertaining to:

☐ Mental Health	☐ Drugs & Alcohol	☐ HIV/AIDS & other communicable diseases	☐ Genetic Testing

Please identify the purpose of your request:

☐ Continued Patient Care	☐ Soc. Service / Disability	☐ Other _____
☐ Insurance	☐ Attorney / Legal	☐
☐ Worker's Compensation	☐ Personal	☐

I understand that:

- I may revoke this authorization at any time.
- The revocation will not apply to information that has already been released in response to this Authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this Authorization, I must do so in writing.
- The procedure for revoking this Authorization is to present my written revocation to the office manager and/or doctor at WFM.

I also understand that:

- I may refuse to sign this Authorization.
- WFM will not condition my treatment (or any payment, enrollment in a health plan, or eligibility for benefits) upon receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire automatically ***two years from the date of signature.***

_____ OR _____ _____

Signature of Patient | Authorized Representative | Date

_____ _____

Witness | Date

Please explain the Representative's authority to act on behalf of the patient:

_____

_____

TO BE COMPLETED BY OFFICE PERSONNEL ONLY

Date Completed: _____ Completed By: _____

Total Pages: _____ Sent Via: Mail Courier Certified Mail Fax Picked-Up

Fax Number: _____ □ Fax Verified □ ID Checked

Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Wakefield Family Medicine is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check the appropriate box(es) in which you would like to receive/send information. If there is another person we can leave information with, please give us their name and phone number in the space provided.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

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