



Email: info@compassionhealthcare.org
Web: compassionhealthcare.org

Caswell Family Medical Center
439 US Hwy 158 West
Yanceyville, NC 27379

Tel: (336) 694-9331
Fax: (336) 694-7511

James Austin Health Center
207 E Meadow Rd, # 6
Eden, NC 27288

Tel: (336) 864-2795
Fax: (336) 864-2895

PATIENT REGISTRATION FORM

(Updated 3/29/2021)

Patient Information:

Dr. Miss Mr. Mrs. Ms. Sir

Name: (Last) (First) (MI) (Previous)

Address: City: ST: Zip:

Phone (Home): (Cell): (Work):

Do you have a preference for a particular Provider? If so, who would you like to see?

If your Primary Care Provider (PCP) is not CHC, please complete the following:

PCP Name:

Practice Name:

PCP Phone Number: ( ) - -

Social Security Number: - - Date of Birth: / /

Gender: Female Male Transgender M Transgender F

Sexual Orientation: Lesbian/Gay Straight Bisexual Something Else Don't Know Not disclosed

Marital Status: Married Single Divorced Widowed Legally Separated Partner

Employment Status: Full Time Part Time Not Employed Self Employed Retired Active Military

Employer Name (if applicable):

Student Status: Full Time Part Time Not a student

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American
White Other Declined

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined

Language: English Spanish Indian Japanese Chinese Korean Other:

Email Address:

What pharmacy do you use?

Housing Status: Homeless Doubling Up Private Residence Group Home Nursing Home

Are you disabled? Yes No Are you a veteran? Yes No

Do you have an Advanced Directive (living will, DNR, etc.)? Yes No

**Emergency Contact:**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Emergency Contact Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_

Phone (Home): \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ (Cell): \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ (Work): \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

**Caregiver's Information (if applicable):**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Caregiver's relationship: Legal Guardian Power of Attorney Other

**CERTIFICATION:**

**I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.**

**Patient (or Guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**NOTICE OF AUTHORIZATIONS & ASSIGNMENT OF BENEFITS**

**Assignment of Insurance Benefits:** I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO COMPASSION HEALTH CARE, INC. or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Compassion Health Care, Inc. is unable to collect from my insurance carrier, for whatever reason.

**Authorization to release non-public information:** I certify that I have read and been offered a copy of the Compassion Health Care, Inc. HIPAA Notice of Privacy Practices, as well as receipt of Compassion Health Care, Inc.'s Office Practices and Patient Rights & Responsibilities. I hereby authorize Compassion Health Care, Inc. and/or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. Compassion Health Care, Inc. reserves the right to revise its Notice of Policy Practices, Office Practices and Patient Rights and Responsibilities at any time. A copy of such revisions will be available upon request.

**Medicare/Medicaid Information:** I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits may be made directly to Compassion Health Care, Inc. or they physician on my behalf.

**Lab Testing:** I understand that I may receive a separate bill if my medical care includes lab services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

**Prescriptions:** I acknowledge that my treating physician/medical provider may obtain a prescription history if it is deemed necessary.

**Consent to Treatment:** I hereby consent to evaluation, testing and treatment as directed by my Compassion Health Care, Inc. physician or those under his/her supervision.

**My signature below certifies that I have read and agree to all of the information stated above.**

**Patient (or Guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Do you wish to enroll for access to your medical records via CHC's patient portal?** Yes No

*\*Note: When we enroll you, you will receive an email at the address you gave us on the first page of this form. You are strongly encouraged to use an email address that only you have access to.*



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### Patient Medical History Information

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list all allergies, including medicines, foods, environmental and betadine: \_\_\_\_\_

Date Form Completed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Do you have, or have you had, any of the following health conditions? (Please check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes (Sugar)    | <input type="checkbox"/> Hay Fever                          | <input type="checkbox"/> Other (Please Describe): _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia                          | _____   |
| <input type="checkbox"/> Asthma/Emphysema    | <input type="checkbox"/> Broken Bones                       | _____   |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Phlebitis                          | _____   |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Skin Disease                       |   |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Gout                               |   |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Rheumatic fever                    |   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> German Measles                     |   |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Chicken Pox                        |   |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Hepatitis                          |   |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Peptic Ulcer                       |   |
| <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Vaginal Infection                  |   |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Sexually Transmitted Disease (STD) |   |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Anemia                             |   |
| <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> High Cholesterol                   |   |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Blood Transfusion                  |   |

**Please check the box for any family members listed that have had any of the following health problems.**

	Father	Mother	Grandfather	Grandmother	Brother	Sister
Diabetes (Sugar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Continue on next page...*

**Have you had any of the following surgeries? (Please check all that apply)**

- |   |                                       |                                       |                                    |                                  |
|---|---------------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Tonsils/Throat | <input type="checkbox"/> Thyroid      | <input type="checkbox"/> Ear          | <input type="checkbox"/> Eye       | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Gall bladder   | <input type="checkbox"/> Appendix     | <input type="checkbox"/> Colon        | <input type="checkbox"/> Kidney    | <input type="checkbox"/> Hernia  |
| <input type="checkbox"/> Bone           | <input type="checkbox"/> Prostate     | <input type="checkbox"/> Circumcision | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Heart   |
| <input type="checkbox"/> Lung           | <input type="checkbox"/> Breast       | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Other: _____ |                                       |                                    |                                  |

**Social History (Please check all that apply):**

- Alcohol Use (any type)      Tobacco use (any type)      "Street" Drug Use (any type)

**Female Patients Only:**

What year was your last delivery? \_\_\_\_\_      Period/Menstrual Cycle: Regular    Irregular

First day of last period (date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Total # Pregnancies: \_\_\_\_    Total # Live Births: \_\_\_\_    Total # Miscarriages/stillbirths: \_\_\_\_    Total # abortions: \_\_\_\_

**Please list all current medications, including birth control and over the counter medications:**

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**Do you have any of the following symptoms or conditions? (Please check all that apply)**

- General Symptoms:**    Fatigue                      Fever/Chills                      Headaches                      Loss of Appetite
- Eyes:**                      Discharge                      Burning/Itching                      Eye Pain                      Loss/Blurred Vision
- Ears, Nose & Throat:**    Ear Pain                      Sinusitis                      Nasal Discharge                      Sore Throat
- Cardiovascular:**                      Chest pain at rest                      Chest pain during strenuous activities  
Shortness of breath while lying down                      Swelling of ankles  
Palpitations
- Respiratory:**                      Coughing                      Wheezing                      Shortness of Breath                      Snoring
- Gastrointestinal:**                      Nausea                      Vomiting                      Diarrhea                      Constipation  
Blood in Stool                      Abdominal Pain                      Heartburn
- Genitourinary:**                      Painful Urination                      Frequency Urinating                      Blood in Urine
- Musculoskeletal:**                      Back Pain                      Neck Pain                      Joint Pains                      Muscle Pain
- Integumentary:**                      Skin rashes                      Changes in moles
- Neurological:**                      Blackouts                      Tingling                      Paresthesia/Numbness                      Local weakness  
Seizure Activity
- Psychiatric:**                      Anxiety                      Depression                      Moodiness
- Endocrine:**                      Excessive Thirst                      Change in Weight
- Hematologic/Lymphatic:** Abnormal Bleeding                      Anemia



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### Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

HIPAA (The Health Insurance Portability and Accountability Act) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method. In order to protect the privacy and confidentiality of your information, please complete the following. This form will tell us how you wish to be contacted and with whom we may discuss your healthcare, insurance and billing questions.

CHC may contact me at the following phone numbers:

Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

CHC has my permission to leave a fully detailed message at: Home Cell Work

CHC has my permission to leave a 'minimum necessary' message at: Home Cell Work

This authorization permits the disclosure of protected health information that includes, but is not limited to, test results, diagnosis, treatment and billing information. This information includes mental illness or developmental disability, psychotherapy notes, HIV/AIDS testing or treatment (including information regarding test order, performance, or results, regardless if the results were positive or negative), sexually transmitted disease, substance abuse, abused of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

I hereby authorize that the protected health information regarding the above-named person may be discussed with me or the following person(s):

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Relationship*

CHC will continue to communicate with you according to your above response(s) until you change your preferences. We will continue to leave appointment confirmations on your primary phone number. You can make a change by completing a new form. By signing below, you grant permission to the communication outlined above.

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent/Legal Gaurdian/Personal Representative (Required if patient is not legally Authorized to sign this form).*

\_\_\_\_\_  
*Relationship to the Patient*



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### Sliding Fee Application

**Please note: Only complete this form if you are in need of financial assistance to help cover your out of pocket health care costs. If this does not apply to you, please skip this form.**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_ (Previous) \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Total Number in Household (including self): \_\_\_\_\_

Please complete the following information for the other members of your household:

	Name	Date of Birth	Also a CHC Patient?
1		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
2		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
3		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
4		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
5		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No
6		___ / ___ / ___	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete the following based on income for everyone listed above:

Income Source	Monthly Amount	Income Source	Monthly Amount
Salary	\$ _____	Unemployment	\$ _____
Social Security	\$ _____	Pension/Retirement	\$ _____
Rental Income/Dividends	\$ _____	Interest	\$ _____
Spousal Support	\$ _____	Child Support	\$ _____
Foster Care	\$ _____	Disability	\$ _____
Other: _____	\$ _____	Other: _____	\$ _____

**Total Monthly Income from All Sources: \$ \_\_\_\_\_**

**Please attach proof/verification for each of the income sources indicated above.**

**Signature:** I hereby certify that the above information concerning my income is true and complete and that I have no income other than that listed above. I promise to notify CHC at once if there is a change in my income, family size, mailing address, or telephone number.

\_\_\_\_\_  
 Patient Signature \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**For office use only:**

I have reviewed the application and determined that the patient:

- is not eligible for sliding fee scale.
- is eligible and has been assigned to:  Slide A  Slide B  Slide C  Slide D  Slide E

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Verification: \_\_\_\_\_BBBBBBBBBBBBBBBBBBBBBBB Effective Dates: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_