Wakefield Family Medicine

A New Meaning to Family Care

Octavian M. Belcea, MD
Family Physician

Medical Patient Registration

Patient Information:

Today's Date: __________________

Title: ♦ Mr. ♦ Mrs. ♦ Ms. ♦ Miss ♦ Dr. ♦ __________________

First Name: ___________________ **Middle**: ___________________ **Last**: ___________________

Address: ____

____

City, State, Zip: ____

Home Phone: _____________________ **Work Phone** (extension): __________________________

Cell Phone: ___________________________ **Preferred Means of Contact**: _________________

Email address: ____

Soc. Sec. Num.: ____________________________ **Birth Date**: ____________________________

Sex:
- ♦ Male
- ♦ Female

Race (optional):
- ♦ African American
- ♦ American Indian
- ♦ Asian
- ♦ Caucasian
- ♦ Hispanic
- ♦ __________________________

Preferred Pharmacy: __________________________**Pharmacy Phone #**: ___________________

How did you hear about us?
- ♦ Internet
- ♦ Insurance
- ♦ Friend/Family
- ♦ Existing Patient
- ♦ Drive-by
- ♦ Advertisement

Insurance Carrier Information:

Patient's Relationship to Insurance Carrier

- ♦ Self: **Please fill out Employer and Health Insurance information only**
- ♦ Spouse
- ♦ Child
- ♦ ________________________

Responsible party (if someone other than patient)

Title: ♦ Mr. ♦ Mrs. ♦ Ms. ♦ Miss ♦ Dr. ♦ __________________

First Name: ___________________ Middle: ___________________ Last: _____________________

Address: ____

City, State, Zip:
____

Home Phone: ______________________ Work Phone (extension):
____

Preferred Means of Contact: ____

Soc. Sec. Num.: ____________________________ Birth Date:
____

Sex:
- ♦ Male
- ♦ Female

Race (optional):
- ♦ African American
- ♦ American Indian
- ♦ Asian
- ♦ Caucasian
- ♦ Hispanic
- ♦ ________________________

Employer Name:
____

Health Insurance Name: ____

ID Number: ______________________________ Group Name/Number: _____________________

Copay Amount: ____________________________ Insurance Phone # _______________________

Medical History Form

Patient's Name:
____

Occupation: ____________________ Date of Birth: ____________________

Reason for visit: ____

Current Illnesses/Problems:

____

____

____

Medications (including vitamins):

____

____

____

____

____

Drug Allergies:

____

Immunizations (year of last):
- Tetanus ___________
- Flu ___________
- Pneumonia ___________
- Other: ____________________

Tests (year of last):
- Cholesterol ___________
- Tuberculosis ___________
- Other: ___________

Family History

	Father	Mother	Child	Bro/Sis	Grandprts
Alcohol	♦	♦	♦	♦	♦
Asthma	♦	♦	♦	♦	♦
Bleeding	♦	♦	♦	♦	♦
Cholesterol	♦	♦	♦	♦	♦
Cancer	♦	♦	♦	♦	♦
Diabetes	♦	♦	♦	♦	♦
Epilepsy/Convulsion	♦	♦	♦	♦	♦
Glaucoma	♦	♦	♦	♦	♦
Heart Disease	♦	♦	♦	♦	♦

	Father	Mother	Child	Bro/Sis	Grandprts
High Blood Pressure	♦	♦	♦	♦	♦
Kidney Disease	♦	♦	♦	♦	♦
Mental Illness	♦	♦	♦	♦	♦
Migraine	♦	♦	♦	♦	♦
Osteoporosis	♦	♦	♦	♦	♦
Stroke	♦	♦	♦	♦	♦
Thyroid Disease	♦	♦	♦	♦	♦
Other: ___________	♦	♦	♦	♦	♦

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Medical History (continued)

Please check any of these if they have occurred in the past year.

- ♦ Abdominal Pain
- ♦ Allergies/Hay Fever
- ♦ Anemia
- ♦ Ankles, Swollen
- ♦ Appetite, loss of
- ♦ Arthritis/Rheumatism
- ♦ Asthma/Wheezing
- ♦ Back Pain
- ♦ Bone Fracture/Joint Injury
- ♦ Bowel Habits, Change in
- ♦ Bronchitis/Chronic Cough
- ♦ Cancer
- ♦ Chest Pain
- ♦ Colitis/Crohn's
- ♦ Constipation
- ♦ Convulsions/Seizures
- ♦ Depression
- ♦ Diabetes
- ♦ Diarrhea
- ♦ Diphtheria
- ♦ Diverticulosis
- ♦ Dizziness/Fainting
- ♦ Ear Infections
- ♦ Ear, Ringing in
- ♦ Eczema
- ♦ Eye Infections
- ♦ Fatigue, Chronic
- ♦ Feet, cold/numb
- ♦ Foot Pain
- ♦ Gall Bladder Trouble
- ♦ Gout
- ♦ Hair Loss
- ♦ Headaches, Frequent
- ♦ Heart Murmur
- ♦ Hemorrhoids
- ♦ Hepatitis
- ♦ Hernia
- ♦ High Blood Pressure
- ♦ Hives
- ♦ Indigestion/Heartburn
- ♦ Infections, Frequent
- ♦ Jaundice
- ♦ Kidney Stones
- ♦ Lactose Intolerance
- ♦ Leg Pain
- ♦ Memory Loss
- ♦ Mental Illness
- ♦ Moodiness, Excessive
- ♦ Muscle Weakness
- ♦ Nausea/Vomiting
- ♦ Nervousness
- ♦ Nose Bleeds
- ♦ Numbness/Tingling
- ♦ Osteoporosis
- ♦ Phobias
- ♦ Pneumonia
- ♦ Psoriasis
- ♦ Rashes
- ♦ Sexual Dysfunction
- ♦ Sinus Trouble
- ♦ Sleep Problems/Sleep Apnea
- ♦ Stool, Bloody/Black
- ♦ Stroke
- ♦ Swallowing Difficulty
- ♦ Throat, Sore
- ♦ Thyroid Disease
- ♦ Tremor/Hands Shaking
- ♦ Ulcers, Peptic
- ♦ Urination, Often/Painful
- ♦ Urine, Bloody
- ♦ Varicose Veins/Phlebitis
- ♦ Venereal Disease
- ♦ Vision, Poor
- ♦ Weight Loss

Other: ____________________

Other: ____________________

Men:

- ♦ Impotence
- ♦ Prostate Disease
- ♦ Urethral Discharge
- ♦ Urination, Weak Stream
- ♦ Urination, >2/night

Women:

- ♦ Birth Control
- ♦ Mammogram, Abnormal
- ♦ Menses, Pain/Irregular
- ♦ Pap Test, Abnormal
- ♦ Pregnant/Planning
- ♦ Sex, Painful

Habits:

- ♦ Tobacco
  - Never used _____
  - Currently use _____
  - Quit (date) _____
- ♦ Alcohol: ______________
- ♦ Caffeine: ___________
- ♦ Diet: _________________
- ♦ Exercise: ______________

Surgeries:

____

____

Hospitalizations:

____

____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A-Patient Giving Consent

Name ____

Address ____

Telephone ________________________________ Email ______________________________

Patient # _______________________ Social Security # ________________________________

Section B-TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations at the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at any time by contacting:

Contact Person: Octavian M. Belcea, MD
Telephone: 919-488-0111
Fax: 919-488-0104
Address: 2810-115 Wakefield Pines Drive, Raleigh, NC 27614

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: ____________________________________ Date: _________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____
Relationship to Patient: ____

The Epworth Sleepiness Scale

Name: ____

Today's Date: __________________________________

Your Age (years): ______________________________

Your Sex: ____ Male ____ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the *most appropriate number* for each situation.

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation:	Chance of Dozing
Sitting and reading	____________________
Watching TV	____________________
Sitting, inactive in a public place (e.g. theater or meeting)	____________________
As a passenger in a car for an hour without a break	____________________
Lying down to rest in the afternoon when circumstances permit	____________________
Sitting and talking to someone	____________________
Sitting quietly after lunch without alcohol	____________________
In a car, while stopped for a few minutes in traffic	____________________
TOTAL	____________________

UNDERSTANDING YOUR SCORE
0–10: Normal range in healthy adults
11–14: Mild sleepiness
15–17: Moderate sleepiness
18 or higher: Severe sleepiness

If you scored 11 or higher, consider seeing a sleep medicine specialist to diagnose and treat the cause of your sleepiness.

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Octavian M. Belcea, MD
Family Physician

Patient Questionnaire

How did you hear about us? ______________________________

Do you have any concerns with your skin?

- Brown spots/Sun spots ______________________________
- Frownlines/Crow's feet ______________________________
- Smoother Skin ______________________________
- Wrinkles ______________________________
- Smaller Pores ______________________________
- Brighter Skin ______________________________
- Jowls/Loose skin ______________________________

Patients Condition:

Wrinkles	Minimal	Moderate	Severe
Hyperpigmention	Minimal	Moderate	Severe
Large Pores	Minimal	Moderate	Severe
Laxity	Minimal	Moderate	Severe
Sagging neck	Minimal	Moderate	Severe
Frown lines/Crow's feet	Minimal	Moderate	Severe

Body Concerns:

Muffin tops	Minimal	Moderate	Severe
Saddle bags	Minimal	Moderate	Severe
Sagging knees	Minimal	Moderate	Severe
Scars	Minimal	Moderate	Severe

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Octavian M. Belcea, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- θ Individual refused to sign
- θ Communication barriers prohibited obtaining the acknowledgement
- θ An emergency situation prevented us from obtaining acknowledgement
- θ Other (Please Specify)

____

____

____

Wakefield Family Medicine
A New Meaning to Family Care

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

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Octavian M. Belcea, MD

Family Physician

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 to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
θ Voice Mail	θ Results of lab tests/x-rays θ Other_______________________________________
θ Give information to employer θ Give information to school	θ Appointment absentee information
θ Spouse	θ Family billing information θ Financial θ Medical as follows: ____________________________
θ Parent (provide name)_________________________ ____	θ Family Billing Information θ Financial θ Medical as follows: ____________________________
θ Other (provide name) __________________________ ____	θ Financial θ Medical as follows ____________________________
θ Support Group (provide name)___________________	θ Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Wakefield Family Medicine.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____Date ___________________

Signature of Patient or Personal Representative

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

____

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Family Physician

Office Policies

Effective 09/24/2009

- Your estimated portion or co-pay is due at the time service is rendered. There are times when an insurance company will pay more than expected. In these circumstances any money owed to the patient under the amount of $100.00 will be left as a credit on the account unless requested by the patient. Refunds will be mailed within 4 to 6 weeks.

- Patients that fail to show for an appointment or cancel an appointment that is for an office visit with less than a 24 hours notice will be charged a fee of **$50.00. _____Please Initial**

- Patients that fail to show for an appointment or cancel an appointment that is for a physical or procedure with less than a 24 hours notice will be charged a fee of **$75.00_____Please Initial**

- There will be a fee of **$ 40.00** for all **returned checks.**

- We are happy to file insurance for you but please be aware that any portion not paid by your insurance will be your responsibility. We are not responsible for any discrepancies between our estimate and the actual payment from your insurance company.

- Account balances will be subject to 1.5% interest fee each month if unpaid after three months.

We appreciate the opportunity to provide you with care, in understanding that these office policies help our office run smoothly. If you would like a copy of our office policies please let us know.

I ___________________________________have read the information and fully understand its content.

____________________________________ ________________________

Signature Date

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