Dear Patient,

Thank you for considering us to be your primary healthcare provider. In order to allow our staff and practitioners to focus their energy on your healthcare needs, please take a few minutes to read and fully complete the enclosed packet of information. (Please provide an **accurate** phone number for contact purposes.)

Please be sure to bring your completed packet back to our office at least three days prior to your appointment. If you need assistance completing the packet, please contact our office. If for any reason you have not completed and returned this packet at that time, our office will contact you to have it brought in by the end of that business day. Failure to do so will result in your appointment being canceled and rescheduled for a later date.

As a courtesy, two days prior to your appointment, our office will send out a reminder call regarding your appointment date and time.

We also have 7 convenient Plus Urgent Care Offices to serve your health care needs (listed below). Please visit https://caldwellwaittimes.com/ to check current wait times.

Thank you!

UNC Health Caldwell

Anderson PLUS Urgent Care
270 Pine Mountain Rd., Suite 4
Hudson, NC 28638

Blowing Rock PLUS Urgent Care
8439 Valley Blvd.
Blowing Rock, N.C. 28605

PLUS Urgent Care Hickory
36 14th Avenue NE
Hickory, NC 28601

Rivercrest PLUS Urgent Care
160 River Bend Dr. Ste. A
Granite Falls, NC 28630

Robbins PLUS Urgent Care
322 Mulberry St. SW
Lenoir, NC 28645

Southfork PLUS Urgent Care
1731 Connelly Springs Road
Lenoir, NC 28645

The Falls Pediatrics PLUS Urgent Care
4355 Hickory Blvd. #3
Granite Falls, NC 28630

All Plus Urgent Care locations are conveniently open: MON-FRI **8AM-7:30PM** & SAT-SUN **8AM-4PM**

Important Information for New Patients

We are a **Patient Centered Medical Home**, meaning we focus on:

- Enhancing Patient Experience
- Improving Population Health
- Reducing Costs
- Improving Provider and Staff Work Life

We want to partner with you and your family to understand and respect your unique needs, culture, values, and preferences. Along with your physician and other healthcare providers, you are the most important person in managing your health!

MEDICAL RECORDS

Your medical records may also be obtained through the office by signing a release of information form and in some instances- if the records are sent to another healthcare provider, a form is not required. We are happy to transfer your records to other healthcare providers per your request.

MAKING AND CANCELING APPOINTMENTS

Appointments may be scheduled through the office or via MyUNCChart.

- Patients who present to the clinic 15 minutes *after* the appointment time for clinic visits and arrival time for procedures will be considered **late**.
- Patients who do not attend their scheduled appointment will be considered **no- show patients**.
- Patients who notify a member of the department scheduling staff *more than 24* hours before their scheduled appointment to cancel the appointment via MyChart note, phone call, in person, voicemail, or vendor (e.g., TeleVox) appointment reminder responses are considered a **patient cancellation**.
- Patients who notify a member of the scheduling staff *less than 24 hours* before their scheduled appointment to cancel the appointment via MyChart note, voice mail, in-person, or phone call are consider a **same-day patient cancellation.**
- For the first and second occurrences of same-day cancellations and no-shows, patients will be given notified via phone call and/or letter. Patients who no-show, arrive late (and cannot be accommodated the same day), or cancel within 24 hours of the scheduled appointment **three times within 12 months** with an individual clinic or provider, may be dismissed from the provider's or discipline's clinic. All patient dismissals are made at the provider's discretion.
- It is the responsibility of the patient to:
    - Arrive for their scheduled appointment at the instructed arrival time to insure timely operation of the clinic and a positive experience for themselves and other patients. Late patients are not guaranteed to be seen for their scheduled appointment and may need to be rescheduled.
    - Notify the scheduling department as early as possible of a cancellation so they can be rescheduled, and the slot can be available to other patients.

It is of utmost importance to UNC Health Caldwell that your appointments are kept so that we can work together to improve and maintain your health. Because we value your time and health, we enforce a No-Show Policy consistently with all patients. Patients who miss an appointment without prior notification to the office may pose a risk to not only their own health, but also may pose a risk to other members of the community.

NOTICE:
NORTH CAROLINA CONTROLLED SUBSTANCE REGISTRY

Because of the enormous problem of misuse of prescription drugs, North Carolina's Department of Health and Human Services maintains a website that tracks prescriptions including controlled substances like narcotics and sedatives. Examples of those medications include Valium, Percocet, OxyContin, Vicodin, Xanax, Lortab, Etc.

The Providers (Doctor's, Physician Assistants, and Family Nurse Practitioners) utilize this website to screen and confirm all medications that have been prescribed to patients seeking care in this Clinic. This website assists the providers in providing safe, effective medication management for patients.

Additionally, the providers do not provide pain management services for chronic conditions. **If** you are under another doctor's care for pain management, then additional pain medications will not be prescribed.

UNC Health Caldwell complies with all applicable laws governing healthcare. For questions or clarification, please call Risk Management at 828-757-5456.

UNC HEALTH Caldwell

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

PATIENT INFORMATION

Full Name:	Address:
Birth Date:	City:
Age:	State: Zip:
Sex: ❑ Male ❑ Female	Primary Phone:
SSN#:	Work Phone:
Employment Status:	Mobile Phone:
Employer:	Secondary Phone:
Retirement Date *(if applicable)*:	Email:
Marital Status: ***Please Check One*** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Domestic Partner	Race: ***Please Check One*** ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Other Pacific Islander ❑ Unknown/Other Race ❑ White or Caucasian
Ethnicity: ***Please Check One*** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Emergency Contact:
	Emergency Number:
	Relationship of Emergency Contact:
Preferred Language:	
If Patient is a MINOR: *Please Complete this Section*	
Mother's Name:	Father's Name
Mother's Birthdate:	Father's Birthdate:
Mother's Phone:	Father's Phone:
Is Mother the Guarantor? Y N	Is Father the Guarantor? Y N

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Member Number/ID for Patient:	Member Number/ID for Patient:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name *(name on card)*:	Subscriber Name *(name on card)*:
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to Patient:	Relationship to Patient:

UNC HEALTH Caldwell

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

UNC HEALTH Caldwell

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

UNC HEALTH Caldwell

NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: ❑ Male ❑ Female			
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy			
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?		***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N	
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N	
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N	

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NEW PATIENT DEMOGRAPHICS & MEDICAL HISTORY

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

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UNC HEALTH

Patient Request for Access to Protected Health Information (PHI)

HIM# 1409s

Patient's Name (print)	*Phone Number*	*Date of Birth*
Patient's Address		*Medical Record #*

INFORMATION THAT CAN BE RELEASED: If specific dates only, list dates: _____

Type of Records Being Requested (*check all that apply*):

- ☐ **All My Medical Records**
- ☐ Urgent Care Center Notes
- ☐ Operative/Procedure Notes
- ☐ Discharge Summaries
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Radiology Images/CD (Imaging Support)
- ☐ Clinic Notes (outpatient)
- ☐ Other (describe in detail): _____
- ☐ Emergency Dept. Notes
- ☐ History and Physical
- ☐ Provider Orders
- ☐ Consultations
- ☐ Progress Notes (inpatient)
- ☐ Patient Billing Records
- ☐ Nursing Notes

Person/Company that you wish to receive your records

Name: _____

Address: _____

_____

Phone Number: _____

Fax (if applicable): _____

Please check if you wish to authorize the release of sensitive medical information: ☐ Mental Health/Psychiatric Treatment ☐ Genetic Testing Information ☐ Alcohol or Substance Abuse Treatment ☐ Sexually Transmitted Infection/HIV/AIDS Treatment(s) or Test(s)

Format Requested / Delivery Method

- ☐ Mail paper records to address listed above
- ☐ Review or pick up paper records in Health Information Management (HIM) Department
- ☐ Verbal release to person identified above
- ☐ Fax to number listed above (Health care providers only; no personal faxes)
- ☐ Other: (*describe*) _____

Fees: A reasonable cost-based fee may be charged for copies of records being requested. Patients may request a cost estimate from HIM in advance.

- ☐ Receive electronically via email* ☐Encrypted ☐Unencrypted
- ☐USB* Data provided in unencrypted electronic formats poses inherent risks of potential interception or compromise.

*If I choose to receive my medical information via an unencrypted electronic format, I accept all associated risks.

- ☐ Release to web portal via MyUNC Chart in electronic format. (Access will only be available for 30 days; you may print and/or save a copy for personal use) **This option is only available for records that were created in Epic.

If you do not have a MyUNC Chart you may sign up for an account here: https://myuncchart.org/mychart/

Expiration: Unless previously revoked, this Authorization will expire on the following date, event or condition: (*list date, event or condition*) _____. If I fail to specify an expiration date or event or condition, this Authorization shall remain in effect for **one (1) year** from the date I sign it. **Please note that records created after the date of signature on this form but prior to the expiration date will be released pursuant to this form unless otherwise indicated above.**

Signature of Patient	*Date*	*Time*
OR Signature of Authorized Representative	*Date*	*Time*
Printed Name of Authorized Representative	*Phone Number of Authorized Representative*	
Explain Representative's authority to act on behalf of the Patient:		